

HOUSE BILL No. 1727

DIGEST OF HB 1727 (Updated February 14, 2001 2:32 PM - DI 73)

Citations Affected: IC 4-22; IC 12-7; IC 12-10; IC 12-15; IC 12-16; IC 12-17.6; IC 12-17.7; IC 12-17.8; IC 34-30; IC 35-43; noncode.

Synopsis: Medicaid and uninsured parents program. Establishes the uninsured parent's program (program) within the office of the secretary of family and social services to provide health insurance coverage to certain uninsured individuals. Provides eligibility requirements that an individual must meet in order to enroll in the program. Provides that providers enrolled under the Medicaid program are considered providers for the program. Repeals the hospital care for the indigent program. Provides for funding of the uninsured parents program. Makes changes to the Medicaid disproportionate share hospital payment structure. Requires each nursing home to annually evaluate each patient and provide the information to the office of Medicaid policy and planning (OMPP) and requires OMPP to review evaluations and, if OMPP determines that an individual's needs can be met in a setting other than a nursing home, inform the individual of that determination and the services that are available to allow the individual to reside in a non-nursing home setting. Provides that OMPP may not increase the base amount used for calculation of reimbursement rates for inpatient and outpatient hospital services over the base amount in effect on January 1, 2001. Requires each state department and agency and each local governmental unit to cooperate with OMPP who shall conduct a study to examine means by which to cover Medicaid eligible care provided by the local units with state or local funding. Repeals certain statutes allowing the temporary admission of an Indiana resident to a nursing home without completing a preadmission screening.

Effective: July 1, 2000 (retroactive); January 1, 2001 (retroactive); July 1, 2001; January 1, 2002; June 30, 2002; July 1, 2002; July 1, 2003

Crawford, Friend, Kuzman

January 17, 2001, read first time and referred to Committee on Ways and Means. February 14, 2001, amended, reported — Do Pass.



First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2000 General Assembly.

HOUSE BILL No. 1727

A BILL FOR AN ACT to amend the Indiana Code concerning health and human services and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

1	SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.273-1999.
2	SECTION 160, IS AMENDED TO READ AS FOLLOWS
3	[EFFECTIVE JANUARY 1, 2002]: Sec. 37.1. (a) This section applies
4	to a rulemaking action resulting in any of the following rules:
5	(1) An order adopted by the commissioner of the Indiana

- (1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.
- (2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.
- (3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.
- (4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.
- (5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107

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1	and declared necessary to meet an emergency.
2	(6) A rule required under IC 24-4.5-1-106 that is adopted by the
3	department of financial institutions and declared necessary to
4	meet an emergency under IC 24-4.5-6-107.
5	(7) A rule adopted by the Indiana utility regulatory commission to
6	address an emergency under IC 8-1-2-113.
7	(8) An emergency rule jointly adopted by the water pollution
8	control board and the budget agency under IC 13-18-13-18.
9	(9) An emergency rule adopted by the state lottery commission
10	under IC 4-30-3-9.
11	(10) A rule adopted under IC 16-19-3-5 that the executive board
12	of the state department of health declares is necessary to meet an
13	emergency.
14	(11) An emergency rule adopted by the Indiana transportation
15	finance authority under IC 8-21-12.
16	(12) An emergency rule adopted by the insurance commissioner
17	under IC 27-1-23-7.
18	(13) An emergency rule adopted by the Indiana horse racing
19	commission under IC 4-31-3-9.
20	(14) An emergency rule adopted by the air pollution control
21	board, the solid waste management board, or the water pollution
22	control board under IC 13-15-4-10(4) or to comply with a
23	deadline required by federal law, provided:
24	(A) the variance procedures are included in the rules; and
25	(B) permits or licenses granted during the period the
26	emergency rule is in effect are reviewed after the emergency
27	rule expires.
28	(15) An emergency rule adopted by the Indiana election
29	commission under IC 3-6-4.1-14.
30	(16) An emergency rule adopted by the department of natural
31	resources under IC 14-10-2-5.
32	(17) An emergency rule adopted by the Indiana gaming
33	commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.
34	(18) An emergency rule adopted by the alcoholic beverage
35	commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
36	IC 7.1-3-20-24.4.
37	(19) An emergency rule adopted by the department of financial
38	institutions under IC 28-15-11.
39	(20) An emergency rule adopted by the office of the secretary of
40	family and social services under IC 12-8-1-12.
41	(21) An emergency rule adopted by the office of the children's

 $health\ insurance\ program\ under\ IC\ 12\text{-}17.6\text{-}2\text{-}11.$

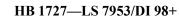


1	(22) An emergency rule adopted by the office of the uninsured
2	parents program under IC 12-17.7-2-7.
3	(b) The following do not apply to rules described in subsection (a):
4	(1) Sections 24 through 36 of this chapter.
5	(2) IC 13-14-9.
6	(c) After a rule described in subsection (a) has been adopted by the
7	agency, the agency shall submit the rule to the publisher for the
8	assignment of a document control number. The agency shall submit the
9	rule in the form required by section 20 of this chapter and with the
10	documents required by section 21 of this chapter. The publisher shall
11	determine the number of copies of the rule and other documents to be
12	submitted under this subsection.
13	(d) After the document control number has been assigned, the
14	agency shall submit the rule to the secretary of state for filing. The
15	agency shall submit the rule in the form required by section 20 of this
16	chapter and with the documents required by section 21 of this chapter.
17	The secretary of state shall determine the number of copies of the rule
18	and other documents to be submitted under this subsection.
19	(e) Subject to section 39 of this chapter, the secretary of state shall:
20	(1) accept the rule for filing; and
21	(2) file stamp and indicate the date and time that the rule is
22	accepted on every duplicate original copy submitted.
23	(f) A rule described in subsection (a) takes effect on the latest of the
24	following dates:
25	(1) The effective date of the statute delegating authority to the
26	agency to adopt the rule.
27	(2) The date and time that the rule is accepted for filing under
28	subsection (e).
29	(3) The effective date stated by the adopting agency in the rule.
30	(4) The date of compliance with every requirement established by
31	law as a prerequisite to the adoption or effectiveness of the rule.
32	(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and
33	IC 22-8-1.1-16.1, a rule adopted under this section expires not later
34	than ninety (90) days after the rule is accepted for filing under
35	subsection (e). Except for a rule adopted under subsection (a)(14), the
36	rule may be extended by adopting another rule under this section, but
37	only for one (1) extension period. A rule adopted under subsection
38	(a)(14) may be extended for two (2) extension periods. Except for a
39	rule adopted under subsection (a)(14), for a rule adopted under this
40	section to be effective after one (1) extension period, the rule must be
41	adopted under:



(1) sections 24 through 36 of this chapter; or

1	(2) IC 13-14-9;
2	as applicable.
3	(h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires
4	on the earlier of the following dates:
5	(1) The expiration date stated by the adopting agency in the rule.
6	(2) The date that the rule is amended or repealed by a later rule
7	adopted under sections 24 through 36 of this chapter or this
8	section.
9	(1) (i) This section may not be used to readopt a rule under
.0	IC 4-22-2.5.
1	SECTION 2. IC 12-7-2-24.5 IS ADDED TO THE INDIANA CODE
2	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
.3	JANUARY 1, 2002]: Sec. 24.5. "Caretaker relative" for purposes
4	of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2.
.5	SECTION 3. IC 12-7-2-52.2, AS ADDED BY P.L.273-1999,
6	SECTION 163, IS AMENDED TO READ AS FOLLOWS
.7	[EFFECTIVE JANUARY 1, 2002]: Sec. 52.2. (a) "Crowd out", for
8	purposes of IC 12-17.6, has the meaning set forth in IC 12-17.6-1-2.
9	(b) "Crowd out", for purposes of IC 12-17.7, has the meaning
20	set forth in IC 12-17.7-1-2.
21	SECTION 4. IC 12-7-2-69 IS AMENDED TO READ AS
22	FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69. (a) "Division",
23	except as provided in subsections (b) and (c), refers to any of the
24	following:
25	(1) The division of disability, aging, and rehabilitative services
26	established by IC 12-9-1-1.
27	(2) The division of family and children established by
28	IC 12-13-1-1.
29	(3) The division of mental health established by IC 12-21-1-1.
30	(b) The term refers to the following:
31	(1) For purposes of the following statutes, the division of
32	disability, aging, and rehabilitative services established by
33	IC 12-9-1-1:
34	(A) IC 12-9.
35	(B) IC 12-10.
86	(C) IC 12-11.
37	(D) IC 12-12.
88	(2) For purposes of the following statutes, the division of family
39	and children established by IC 12-13-1-1:
10	(A) IC 12-13.
1	(B) IC 12-14.
12	(C) IC 12 15





1	(D) IC 12-16.
2	(E) IC 12-16.1.
3	(F) IC 12-17.
4	(F) (G) IC 12-17.2.
5	(G) (H) IC 12-17.4.
6	(H) (I) IC 12-18.
7	(I) (J) IC 12-19.
8	(J) (K) IC 12-20.
9	(3) For purposes of the following statutes, the division of mental
10	health established by IC 12-21-1-1:
11	(A) IC 12-21.
12	(B) IC 12-22.
13	(C) IC 12-23.
14	(D) IC 12-25.
15	(c) With respect to a particular state institution, the term refers to
16	the division whose director has administrative control of and
17	responsibility for the state institution.
18	(d) For purposes of IC 12-24, IC 12-26, and IC 12-27, the term
19	refers to the division whose director has administrative control of and
20	responsibility for the appropriate state institution.
21	SECTION 5. IC 12-7-2-76, AS AMENDED BY P.L.128-1999,
22	SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
23	JUNE 30, 2002]: Sec. 76. (a) "Eligible individual", for purposes of
24	IC 12-10-10, has the meaning set forth in IC 12-10-10-4.
25	(b) "Eligible individual" has the meaning set forth in
26	IC 12-14-18-1.5 for purposes of the following:
27	(1) IC 12-10-6.
28	(2) IC 12-14-2.
29	(3) IC 12-14-18.
30	(4) IC 12-14-19.
31	(5) IC 12-15-2.
32	(6) IC 12-15-3.
33	(7) IC 12-16-3.
34	(8) (7) IC 12-17-1.
35	(9) (8) IC 12-20-5.5.
36	SECTION 6. IC 12-7-2-76.5, AS AMENDED BY P.L.95-2000,
37	SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
38	JANUARY 1, 2002]: Sec. 76.5. (a) "Emergency", for purposes of
39	IC 12-20, means an unpredictable circumstance or a series of
40	unpredictable circumstances that:
41	(1) place the health or safety of a household or a member of a
12	household in jeopardy: and





1	(2) cannot be remedied in a timely manner by means other than
2	township assistance.
3	(b) "Emergency", for purposes of IC 12-17.6 and IC 12-17.7, has
4	the meaning set forth in IC 12-17.6-1-2.6. means a medical condition
5	that manifests itself by acute symptoms of such severity, including
6	severe pain, that the absence of immediate medical attention could
7	reasonably be expected by a prudent lay person who possesses an
8	average knowledge of health and medicine to:
9	(1) place an individual's health in serious jeopardy;
10	(2) result in serious impairment to the individual's bodily
11	functions; or
12	(3) result in serious dysfunction of a bodily organ or part of
13	the individual.
14	SECTION 7. IC 12-7-2-104.5, AS ADDED BY P.L.128-1999,
15	SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
16	JUNE 30, 2002]: Sec. 104.5. "Holocaust victim's settlement payment"
17	has the meaning set forth in IC 12-14-18-1.7 for purposes of the
18	following:
19	(1) IC 12-10-6.
20	(2) IC 12-14-2
21	(3) IC 12-14-18.
22	(4) IC 12-14-19.
23	(5) IC 12-15-2.
24	(6) IC 12-15-3.
25	(7) IC 12-16-3.
26	(8) (7) IC 12-17-1.
27	(9) (8) IC 12-20-5.5.
28	SECTION 8. IC 12-7-2-110, AS AMENDED BY P.L.142-2000,
29	SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
30	JULY 1, 2003]: Sec. 110. "Hospital" means the following:
31	(1) For purposes of IC 12-15-11.5, the meaning set forth in
32	IC 12-15-11.5-1.
33	(2) For purposes of IC 12-15-18, the meaning set forth in
34	IC 12-15-18-2.
35	(3) For purposes of IC 12-16, except IC 12-16-1, IC 12-16.1, the
36	term refers to a hospital licensed under IC 16-21.
37	SECTION 9. IC 12-7-2-118.1 IS ADDED TO THE INDIANA
38	CODE AS A NEW SECTION TO READ AS FOLLOWS
39	[EFFECTIVE JUNE 30, 2002]: Sec. 118.1. "Inpatient days", for
40	purposes of IC 12-16.1-8, has the meaning set forth in
41	IC 12-16.1-8-1.
42	SECTION 10. IC 12-7-2-131.3 IS ADDED TO THE INDIANA



1	CODE AS A NEW SECTION TO READ AS FOLLOWS
2	[EFFECTIVE JULY 1, 2001]: Sec. 131.3. "Minimum data set", for
3	purposes of IC 12-15-41, has the meaning set forth in
4	IC 12-15-41-1.
5	SECTION 11. IC 12-7-2-134, AS AMENDED BY P.L.273-1999,
6	SECTION 165, IS AMENDED TO READ AS FOLLOWS
7	[EFFECTIVE JANUARY 1, 2002]: Sec. 134. "Office" means the
8	following:
9	(1) Except as provided in subdivisions (2) and (3), the office of
10	Medicaid policy and planning established by IC 12-8-6-1.
11	(2) For purposes of IC 12-10-13, the meaning set forth in
12	IC 12-10-13-4.
13	(3) For purposes of IC 12-17.6, the meaning set forth in
14	IC 12-17.6-1-4.
15	(4) For purposes of IC 12-17.7, the meaning set forth in
16	IC 12-17.7-1-3.
17	SECTION 12. IC 12-7-2-146, AS AMENDED BY P.L.273-1999,
18	SECTION 166, IS AMENDED TO READ AS FOLLOWS
19	[EFFECTIVE JANUARY 1, 2002]: Sec. 146. "Program" refers to the
20	following:
21	(1) For purposes of IC 12-10-7, the adult guardianship services
22	program established by IC 12-10-7-5.
23	(2) For purposes of IC 12-10-10, the meaning set forth in
24	IC 12-10-10-5.
25	(3) For purposes of IC 12-17.6, the meaning set forth in
26	IC 12-17.6-1-5.
27	(4) For purposes of IC 12-17.7, the meaning set forth in
28	IC 12-17.7-1-4.
29	SECTION 13. IC 12-7-2-149, AS AMENDED BY P.L.14-2000,
30	SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
31	JANUARY 1, 2002]: Sec. 149. "Provider" means the following:
32	(1) For purposes of IC 12-10-7, the meaning set forth in
33	IC 12-10-7-3.
34	(2) For purposes of the following statutes, an individual, a
35	partnership, a corporation, or a governmental entity that is
36	enrolled in the Medicaid program under rules adopted under
37	IC 4-22-2 by the office of Medicaid policy and planning:
38	(A) IC 12-14-1 through IC 12-14-9.5.
39	(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and
40	IC 12-15-34.
41	(C) IC 12-17-10.
42	(D) IC 12-17-11.





1	(E) IC 12 17 6
2	(E) IC 12-17.6. (F) IC 12-17.7.
3	(3) For purposes of IC 12-17-9, the meaning set forth in
4	IC 12-17-9-2.
5	(4) For the purposes of IC 12-17.2, a person who operates a child
6	care center or child care home under IC 12-17.2.
7	(5) For purposes of IC 12-17.4, a person who operates a child
8	caring institution, foster family home, group home, or child
9	placing agency under IC 12-17.4.
10	SECTION 14. IC 12-7-2-164 IS AMENDED TO READ AS
11	FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 164. "Resident" has the
12	following meaning:
13	(1) For purposes of IC 12-10-15, the meaning set forth in
14	IC 12-10-15-5.
15	(2) For purposes of IC 12-16, except IC 12-16-1, IC 12-16.1, an
16	individual who has actually resided in Indiana for at least ninety
17	(90) days.
18	(3) For purposes of IC 12-20-8, the meaning set forth in
19	IC 12-20-8-1.
20	(4) For purposes of IC 12-24-5, the meaning set forth in
21	IC 12-24-5-1.
22	SECTION 15. IC 12-10-12-27 IS AMENDED TO READ AS
23	FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 27. (a) Except as
24	provided in subsection (b), the agency shall, subject to the approval
25	of the division, designate at least one (1) individual who may authorize
26	temporary admittance to a nursing facility under
27	(1) subsection (b); and
28	(2) sections 28, 30, and 31 of this chapter
29	without the approval required under this chapter.
30	(b) An individual designated under subsection (a) may not authorize
31	temporary admittance to a nursing home under subsection (a) for a
32	resident nonresident of Indiana. if the resident:
33	(1) has received treatment from and is being discharged from a
34	hospital that is located in a state other than Indiana; and
35	(2) will be participating in preadmission screening under this
36	chapter.
37	(c) Notwithstanding a rule adopted under section 12 of this chapter,
38	a screening team appointed to screen a nonresident under this section
39	must:
40	(1) conduct its assessment under section 16 of this chapter; and
41	(2) report its findings;
42	within ten (10) days after its appointment.



1	SECTION 16. IC 12-15-1-16.5 IS ADDED TO THE INDIANA
2	CODE AS A NEW SECTION TO READ AS FOLLOWS
3	[EFFECTIVE JULY 1, 2001]: Sec. 16.5. Each state department or
4	agency and each local governmental unit shall cooperate with the
5	office who shall conduct a study to examine means in which to
6	cover Medicaid eligible care provided by the departments,
7	agencies, or units with state or local funding.
8	SECTION 17. IC 12-15-15-1.1, AS AMENDED BY P.L.113-2000,
9	SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
10	JULY 1, 2000 (RETROACTIVE)]: Sec. 1.1. (a) This section applies to
11	a hospital that is:
12	(1) licensed under IC 16-21; and
13	(2) established and operated under IC 16-22-2 or IC 16-23.
14	(b) a state fiscal year ending after June 30, 1997, 2000, in addition
15	to reimbursement received under section 1 of this chapter, a hospital is
16	entitled to reimbursement in an amount calculated from the hospital's
17	cost report filed with the office for the hospital's fiscal period ending
18	during the state fiscal year, equal to the difference between:
19	(1) the amount of payments to the hospital under this article,
20	excluding payments under IC 12-15-16 and IC 12-15-19, for
21	services provided by the hospital during the state fiscal year; and
22	(2) an amount equal to the lesser of the following:
23	(A) The hospital's customary charges for the services
24	described in subdivision (1).
25	(B) A reasonable estimate by the office of the amount that
26	must be paid for the services described in subdivision (1)
27	under Medicare payment principles. as follows:
28	STEP ONE: The office shall identify the aggregate services
29	reimbursed under this article provided by hospitals
30	established and operated under IC 16-22-2, IC 16-22-8, and
31	IC 16-23.
32	STEP TWO: For the aggregated services identified under
33	STEP ONE, the office shall calculate the aggregate payments
34	made under this article to hospitals established and operated
35	under IC 16-22-2, IC 16-22-8, and IC 16-23, excluding
36	payments under IC 12-15-16 and IC 12-15-19.
37 38	STEP THREE: For the period beginning January 1, 2001, and ending June 30, 2001, and for a state fiscal year ending after
38 39	•
39 40	June 30, 2001, the office shall calculate an amount equal to
40	one hundred fifty percent (150%) of a reasonable estimate of

the amount that would have been paid in the aggregate by the

office for services described in STEP ONE under Medicare



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1	payment principles.
2	STEP FOUR: Subtract the amount calculated under STEP
3	TWO from the amount calculated under STEP THREE.
4	STEP FIVE: From the amount calculated under STEP FOUR,
5	distribute to a hospital established and operated under
6	IC 16-22-8 an amount equal to one hundred percent (100%)
7	of the difference between:
8	(A) the aggregate payments for covered services made
9	under this article to the hospital, excluding payments
10	under IC 12-15-16 and IC 12-15-19; and
11	(B) a reasonable estimate of the amount that would have
12	been paid for the services described in subdivision (1)
13	under Medicare payment principles.
14	The actual distribution of the amount calculated under this
15	STEP shall be made pursuant to the terms and conditions
16	provided for the hospital in the state plan for medical
17	assistance.
18	STEP SIX: Subtract the amount calculated under STEP FIVE
19	from the amount calculated under STEP FOUR.
20	STEP SEVEN: Distribute an amount equal to the amount
21	calculated under STEP SIX to the eligible hospitals described
22	in subsection (c) in proportion to each hospital's hospital
23	specific limit under 42 U.S.C. 1396r-4(g), as determined by the
24	office.
25	(c) Subject to subsection (e), reimbursement under this section
26	consists of a single payment made after the close of each state fiscal
27	year. Payment for a state fiscal year ending after June 30, 2001,
28	shall be made before December 31 following the state fiscal year's
29	end. A payment described in this subsection is not due to a hospital
30	unless:
31	(1) the hospital is licensed under IC 16-21 and is established
32	and operated under IC 16-22-2 or IC 16-23; and
33	(2) an intergovernmental transfer is made under subsection (d).
34	(d) Subject to subsection (e), a hospital may make an
35	intergovernmental transfer under this subsection, or an
36	intergovernmental transfer may be made on behalf of the hospital, after
37	the close of each state fiscal year. An intergovernmental transfer under
38	this subsection shall be made to the Medicaid indigent care trust fund
39	in an amount equal to eighty-five percent (85%) of the amount
40	determined to be distributed to the hospital under STEP FIVE of
41	subsection (b). The intergovernmental transfer must be used to fund
42	the state's share of payments under this section and a portion of the



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1	state's share of disproportionate share payments under
2	IC 12-15-20-2(2), and payments for the uninsured parents program
3	under IC 12-15-20-2(5).
4	(e) An entity A hospital making an intergovernmental transfer
5	under subsection (d) may appeal under IC 4-21.5 the amount
6	determined by the office to be paid the hospital under STEP SEVEN
7	of subsection (b). The periods described in subsections (c) and (d) for
8	a hospital to make an intergovernmental transfer are tolled pending
9	the administrative appeal and any judicial review initiated by the
10	hospital under IC 4-21.5.
11	(f) The office may not implement this section until the federal
12	Health Care Financing Administration has issued its approval of the
13	amended state plan for medical assistance. The office may determine
14	not to continue to implement this section if federal financial
15	participation is not available.
16	(g) For the state fiscal year beginning July 1, 2000, and ending
17	June 30, 2001, the amount calculated under STEP THREE of
18	subsection (b) shall be adjusted to account for the portion of the
19	state fiscal year prior to the effective date of the federal regulation
20	establishing the Medicaid upper payment limit for non-state
21	government owned or operated hospitals at one hundred fifty
22	percent (150%) of Medicare reimbursement rates.
23	(h) For purposes of calculating the amount under STEP THREE
24	of subsection (b), the amount attributable to the period of the state
25	fiscal year described in subsection (g) shall be the maximum

(h) For purposes of calculating the amount under STEP THREE of subsection (b), the amount attributable to the period of the state fiscal year described in subsection (g) shall be the maximum payment amount available without exceeding the Medicaid upper payment limit applicable for non-state owned or operated hospitals for that period.

SECTION 18. IC 12-15-15-9, AS AMENDED BY P.L.113-2000, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 9. (a) Subject to subsections (e) and (f), for each state fiscal year beginning on or after July 1, 1997, ending June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, and June 30, 2002, a hospital is entitled to a payment under this section.

- (b) Total payments to hospitals under this section for a state fiscal year shall be equal to all amounts transferred from the hospital care for the indigent fund for Medicaid current obligations during the state fiscal year, including amounts of the fund appropriated for Medicaid current obligations and funds available under IC 12-16-14.1-3.
- (c) The payment due to a hospital under this section must be based on a policy developed by the office. The policy:
 - (1) is not required to provide for equal payments to all hospitals;



1	(2) must attempt, to the extent practicable as determined by the
2	office, to establish a payment rate that minimizes the difference
3	between the aggregate amount paid under this section to all
4	hospitals in a county for a state fiscal year and the amount of the
5	county's hospital care for the indigent property tax levy for that
6	state fiscal year; and
7	(3) must provide that no hospital will receive a payment under
8	this section less than the amount the hospital received under
9	IC 12-15-15-8 for the state fiscal year ending June 30, 1997.
10	(d) Following the transfer of funds under subsection (b), an amount
11	equal to the amount determined in the following STEPS shall be
12	deposited in the Medicaid indigent care trust fund under
13	IC 12-15-20-2(2) and used to fund a portion of the state's share of the
14	disproportionate share payments to providers for the state fiscal year:
15	STEP ONE: Determine the difference between:
16	(A) the amount transferred from the state hospital care for the
17	indigent fund under subsection (b); and
18	(B) thirty-five million dollars (\$35,000,000).
19	STEP TWO: Multiply the amount determined under STEP ONE
20	by the federal medical assistance percentage for the state fiscal
21	year.
22	(e) If funds are transferred to the Medicaid program under
23	IC 12-16-14.1-2(f), those funds constitute the state's share of
24	funding for payments to hospitals under this subsection. A
25	payment under this subsection shall be made to all hospitals that
26	received a payment under this section for the state fiscal year
27	beginning July 1, 2001, and ending June 30, 2002. Payments under
28	this subsection shall be in proportion to each hospital's payment
29	under this section for the state fiscal year beginning July 1, 2001,
30	and ending June 30, 2002.
31	(f) If the office of the uninsured parents program established by
32	IC 12-17.7-2-1 does not implement an uninsured parents program
33	before July 1, 2003, a hospital is entitled to a payment under this
34	section for each state fiscal year beginning on or after July 1, 2003.
35	SECTION 19. IC 12-15-15-11 IS ADDED TO THE INDIANA
36	CODE AS A NEW SECTION TO READ AS FOLLOWS
37	[EFFECTIVE JANUARY 1, 2001 (RETROACTIVE)]: Sec. 11.
38	Hospitals licensed under IC 16-21 that are established and
39	operated under IC 16-22 or IC 16-23 are nominal charge hospitals
40	for purposes of the Medicaid program.
41	SECTION 20. IC 12-15-15-12 IS ADDED TO THE INDIANA

CODE AS A NEW SECTION TO READ AS FOLLOWS



1	[EFFECTIVE JULY 1, 2001]: Sec. 12. The office may not increase
2	the base amount used to calculate reimbursement rates for
3	inpatient and outpatient hospital services over the base amount
4	used by the office on January 1, 2001.
5	SECTION 21. IC 12-15-16-2, AS AMENDED BY P.L.113-2000,
6	SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
7	JULY 1, 2000 (RETROACTIVE)]: Sec. 2. (a) For purposes of
8	disproportionate share eligibility, a provider's Medicaid inpatient
9	utilization rate is a fraction (expressed as a percentage) where:
10	(1) the numerator is the provider's total number of Medicaid
11	inpatient days in the most recent year for which an audited cost
12	report is on file with the office; and
13	(2) the denominator is the total number of the provider's inpatient
14	days in the most recent year for which an audited cost report is on
15	file with the office.
16	(b) For purposes of this section, "Medicaid inpatient days" includes
17	all acute care days provided by an acute care excluded distinct part
18	subprovider unit of the provider and inpatient days attributable to
19	Medicaid beneficiaries from other states. The term also includes
20	inpatient days attributable to:
21	(1) Medicaid managed care recipients; and
22	(2) Medicaid eligible patients.
23	attributable to individuals eligible for Medicaid benefits under a
24	state plan approved under 42 U.S.C. 1396a on the days of service:
25	(1) whether attributable to individuals eligible for Medicaid
26	in Indiana or any other state;
27	(2) even if the office did not make payment for any services,
28	including inpatient days that are determined to be medically
29	necessary but for which payment is denied by the office for
30	other reasons; and
31	(3) including days attributable to Medicaid beneficiaries
32	receiving services through a managed care organization or
33	health maintenance organization.
34	However, a day is not a Medicaid inpatient day for purposes of this
35	section if the patient was entitled to both Medicare Part A, as
36	defined by 42 U.S.C. 1395c, and Medicaid on that day.
37	SECTION 22. IC 12-15-16-3, AS AMENDED BY P.L.113-2000,
38	SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
39	JUNE 30, 2002]: Sec. 3. (a) For purposes of disproportionate share

eligibility, a provider's low income utilization rate is the sum of the

following, based on the most recent year for which an audited cost



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report is on file with the office:

1	(1) A fraction (expressed as a percentage) for which:
2	(A) the numerator is the sum of:
3	(i) the total Medicaid patient revenues paid to the provider;
4	plus
5	(ii) the amount of the cash subsidies received directly from
6	state and local governments, including payments made
7	under the hospital care for the indigent program
8	(IC 12-16-2) (before its repeal); and
9	(B) the denominator is the total amount of the provider's
10	patient revenues paid to the provider, including cash subsidies;
11	and
12	(2) A fraction (expressed as a percentage) for which:
13	(A) the numerator is the total amount of the provider's charges
14	for inpatient services that are attributable to care provided to
15	individuals who have no source of payment; and
16	(B) the denominator is the total amount of charges for
17	inpatient services.
18	(b) The numerator in subsection (a)(1)(A) does not include
19	contractual allowances and discounts other than for indigent patients
20	not eligible for Medicaid.
21	SECTION 23. IC 12-15-19-2.1, AS ADDED BY P.L.113-2000,
22	SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
23	JULY 1, 2000 (RETROACTIVE)]: Sec. 2.1. (a) For each state fiscal
24	year ending on or after June 30, 2000, the office shall develop a
25	disproportionate share payment methodology that ensures that each
26	hospital qualifying for disproportionate share payments under
27	IC 12-15-16-1(a) timely receives total disproportionate share payments
28	that do not exceed the hospital's hospital specific limit provided under
29	42 U.S.C. 1396r-4(g). The payment methodology as developed by the
30	office must:
31	(1) maximize disproportionate share hospital payments to
32	qualifying hospitals to the extent practicable;
33	(2) take into account the situation of those qualifying hospitals
34	that have historically qualified for Medicaid disproportionate
35	share payments; and
36	(3) ensure that payments net of intergovernmental transfers made
37	by or on behalf of qualifying hospitals are equitable.
38	(b) Total disproportionate share payments to a hospital under this
39	chapter shall not exceed the hospital specific limit provided under 42
40	U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year
41	shall be determined by the office taking into account data provided by
42	each hospital that is considered reliable by the office based on a system



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1	of periodic audits, the use of trending factors, and an appropriate base
2	year determined by the office. The office may require independent
3	certification of data provided by a hospital to determine the hospital's
4	hospital specific limit.
5	(c) The office shall include a provision in each amendment to the
6	state plan regarding Medicaid disproportionate share payments that the
7	office submits to the federal Health Care Financing Administration
8	that, as provided in 42 CFR 447.297(d)(3), allows the state to make
9	additional disproportionate share expenditures after the end of each
10	federal fiscal year that relate back to a prior federal fiscal year.
11	However, the total disproportionate share payments to:
12	(1) each individual hospital; and
13	(2) all qualifying hospitals in the aggregate;
14	may not exceed the limits provided by federal law and regulation.
15	(d) The office shall, in each state fiscal year, provide sufficient
16	funds that, when added to the federal medical assistance percentage

- (d) The office shall, in each state fiscal year, provide sufficient funds that, when added to the federal medical assistance percentage figure described in 42 U.S.C. 1396d(b), total a minimum of twenty-six million dollars (\$26,000,000) as the state's share of Medicaid disproportionate share expenditures for acute care hospitals licensed under IC 16-21 and private psychiatric institutions licensed under IC 12-25 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:
 - (1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and
 - (2) must be in an amount equal to the amount that results from the following calculation:

STEP ONE: Multiply twenty-six million dollars (\$26,000,000) by the federal medical assistance percentage. STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars (\$26,000,000).

SECTION 24. IC 12-15-19-10, AS AMENDED BY P.L.113-2000, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 10. (a) This subsection applies For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, If the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

(1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate







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1	share allocation The total amount paid to municipal
2	disproportionate share providers under IC 12-15-16-1(b) may not
3	exceed twenty-two million dollars (\$22,000,000). (as defined in
4	42 U.S.C. 1396r-4(f)(2)).
5	(2) After the state makes all payments under subdivision (1), if
6	the state fails to exceed the state disproportionate share allocation
7	(as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
8	disproportionate share expenditures for institutions for
9	mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state
10	shall make community mental health center disproportionate
11	share provider payments to providers qualifying under
12	IC 12-15-16-1(c). The total paid to the qualified community
13	mental health center disproportionate share providers under
14	section 9(a) of this chapter, including the amount of expenditures
15	certified as being eligible for federal financial participation under
16	IC 12-15-18-5.1(e), may not exceed must be at least six million
17	dollars (\$6,000,000).
18	(3) After the state makes all payments under subdivision (2), if
19	the state fails to exceed the state disproportionate share allocation
20	(as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make
21	disproportionate share provider payments to providers qualifying
22	under IC 12-15-16-1(a).
23	(b) This subsection applies For state fiscal years beginning after
24	June 30, 2000, If the state exceeds the state disproportionate share
25	allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on
26	disproportionate share expenditures for institutions for mental diseases
27	(as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as
28	follows:
29	(1) The state shall make municipal disproportionate share
30	provider payments to providers qualifying under IC 12-15-16-1(a)
31	IC 12-15-16-1(b) until the state exceeds the state disproportionate
32	share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).
33	(2) After the state makes all payments under subdivision (1), if
34	the state fails to exceed the state disproportionate share allocation
35	(as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make
36	municipal disproportionate share provider payments to providers
37	qualifying under IC 12-15-16-1(b). IC 12-15-16-1(a).
38	(3) After the state makes all payments under subdivision (2), if
39	the state fails to exceed the state disproportionate share allocation
40	(as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
41	disproportionate share expenditures for institutions for

mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state



1	shall make community mental health center disproportionate
2	share provider payments to providers qualifying under
3	IC 12-15-16-1(c).
4	SECTION 25. IC 12-15-20-2, AS AMENDED BY P.L.113-2000,
5	SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
6	JULY 1, 2000 (RETROACTIVE)]: Sec. 2. The Medicaid indigent care
7	trust fund is established to pay the state's share of the following:
8	(1) Enhanced disproportionate share payments to providers under
9	IC 12-15-19-1.
10	(2) Subject to subdivision (5), disproportionate share payments
11	to providers under IC 12-15-19-2.1.
12	(3) Medicaid payments for pregnant women described in
13	IC 12-15-2-13 and infants and children described in
14	IC 12-15-2-14.
15	(4) Municipal disproportionate share payments to providers under
16	IC 12-15-19-8.
17	(5) Of the intergovernmental transfers deposited into the
18	Medicaid indigent care trust fund under IC 12-15-15-1.1(d),
19	the following apply:
20	(A) The entirety of the intergovernmental transfers
21	deposited into the Medicaid indigent care trust fund under
22	IC 12-15-15-1.1(d) for the state fiscal years ending on or
23	before June 30, 2000 shall be used to fund the state's share
24	of the disproportionate share payments to providers under
25	IC 12-15-19-2.1.
26	(B) Of the intergovernmental transfers deposited into the
27	Medicaid indigent care trust fund under IC 12-15-15-1.1(d)
28	for state fiscal years ending after June 30, 2000, an amount
29	equal to one hundred percent (100%) of the total
30	intergovernmental transfers deposited into the Medicaid
31	indigent care trust fund under IC 12-15-15-1.1(d) for
32	payments under IC 12-15-15-1.1(b) for the state fiscal year
33	beginning July 1, 1998, and ending June 30, 1999, shall be
34	used to fund the state's share of disproportionate share
35	payments to providers under IC 12-15-19-2.1. The
36	remainder of the intergovernmental transfers under
37	IC 12-15-15-1.1(d) for the state fiscal year shall be
38	transferred to the state uninsured parents program fund
39	established under IC 12-17.8-2-1 to fund the state's share
40	of funding for the uninsured parents program established
41	under IC 12-17.7.
42	(D) If the office of the uninsured parents program



1	established under IC 12-17.7-2-1 does not implement an
2	uninsured parents program before July 1, 2003, the
3	intergovernmental transfers transferred to the state
4	uninsured parents program fund under clause (B) shall be
5	returned to the Medicaid indigent care trust fund to be
6	used to fund the state's share of Medicaid add-on payments
7	to hospitals licensed under IC 16-21 pursuant to a payment
8	methodolgy developed by the office.
9	SECTION 26. IC 12-15-41 IS ADDED TO THE INDIANA CODE
10	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
11	JULY 1, 2001]:
12	Chapter 41. Annual Review of Medicaid Nursing Facility
13	Residents
14	Sec. 1. "Minimum data set" or "MDS" means a core set of
15	screening and assessment elements, including common definitions
16	and coding categories, used as:
17	(1) a comprehensive assessment for all residents of long term
18	care facilities certified to participate in the Medicaid
19	program; and
20	(2) a standardized communication about resident problems,
21	strengths, and conditions within the facilities, between
22	facilities, and between facilities and outside agencies.
23	Sec. 2. A nursing facility certified to provide nursing facility
24	care to Medicaid recipients shall submit to the office annually
25	minimum data set (MDS) information for each of its Medicaid
26	residents.
27	Sec. 3. (a) The office or the office's designated contractor shall
28	evaluate the MDS information submitted for each Medicaid
29	resident. The evaluation must consist of an assessment of the
30	following:
31	(1) The individual's medical needs.
32	(2) The availability of services, other than services provided
33	in a nursing facility, that are appropriate to the individual's
34	needs.
35	(3) The cost effectiveness of providing services appropriate to
36	the individual's needs that are provided outside of, rather
37	than within, a nursing facility.
38	(b) The assessment must be conducted in accordance with rules
39	adopted under IC 4-22-2 by the office.
40	Sec. 4. If the office determines under section 3 that an

individual's needs could be met in a setting other than a nursing

facility and in a cost effective manner, the office shall counsel the



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individual and provide the individual with written notice containing the following:
(1) The reasons for the office's determination.
(2) A detailed description of services available to the individual that, if used by the individual, make the continued placement of the individual in a nursing facility

SECTION 27. IC 12-16-14.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]:

Chapter 14.1. Transfer of Funds to Uninsured Parents Program Sec. 1. (a) All funds in a county hospital care for the indigent fund on June 30, 2002, derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) before January 1, 2002, shall be immediately transferred to the state hospital care for the indigent fund.

- (b) All funds in a county hospital care for the indigent fund on June 30, 2002, derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) on or after January 1, 2002, through June 30, 2002, shall be immediately transferred to the state uninsured parents program fund established under IC 12-17.8-2-1.
- (c) Subject to subsection (e), beginning July 1, 2002, all tax receipts derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) before January 1, 2002, shall be paid into the county general fund. Before the fifth day of each month, all of the tax receipts paid into the general fund under this subdivision during the preceding month shall be transferred to the state hospital care for the indigent fund.
- (d) Beginning July 1, 2002, all tax receipts derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) on or after January 1, 2002, through June 30, 2002, shall be paid into the county general fund. Before the fifth day of each month, all of the tax receipts paid into the general fund under this subdivision during the preceding month shall be transferred to the state uninsured parents program fund established by IC 12-17.8-2-1.
- (e) If the state hospital care for the indigent fund is closed under section 2(e) of this chapter at the time a transfer of receipts is to be made to the fund, the receipts shall be transferred to the state

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inappropriate.

1	uninsured parents program fund established by IC 12-17.8-2-1.
2	Sec. 2. (a) Beginning July 1, 2002, the division shall transfer to
3	the state uninsured parents program fund established by
4	IC 12-17.8-2-1 all funds deposited in the state hospital care for the
5	indigent fund derived from taxes levied under IC 12-16-14-1(1)
6	(before its repeal) or allocated under IC 12-16-14-1(2) (before its
7	repeal) for the period beginning January 1, 2002, through June 30
8	2002. Before the fifth day of each month, all such funds deposited
9	during the preceding month shall be transferred to the state
10	uninsured parents program fund established by IC 12-17.8-2-1.
11	(b) Subject to subsections (c), (d), and (f), beginning July 1
12	2002, all funds deposited in the state hospital care for the indigen
13	fund derived from taxes levied under IC 12-16-14-1(1) (before its
14	repeal) or allocated under IC 12-16-14-1(2) (before its repeal)
15	before January 1, 2002, shall be used by the division to pay claims
16	for services:
17	(1) eligible for payment under the hospital care for the
18	indigent program (before its repeal); and
19	(2) provided before July 1, 2002.
20	(c) This section does not delay, limit, or reduce either of the
21	following:
22	(1) The appropriation from the state hospital care for the
23	indigent fund for Medicaid current obligations for the state
24	fiscal year beginning July 1, 2000, and ending June 30, 2001
25	under P.L.273-1999, SECTION 8, for purposes of
26	IC 12-15-15-9(a) through IC 12-15-15-9(d) for the state fisca
27	year beginning July 1, 2000, and ending June 30, 2001.
28	(2) The transfer of additional funds from the state hospital
29	care for the indigent fund for Medicaid current obligations
30	anticipated under IC 12-15-15-9(b) for purposes of
31	IC 12-15-15-9(a) through IC 12-15-15-9(d) for the state fisca
32	year beginning July 1, 2000, and ending June 30, 2001.
33	(d) The division shall cooperate with the office of Medicaio
34	policy and planning established under IC 12-15-1-1 in causing the
35	appropriations and transfers from the state hospital care for the
36	indigent fund described in subsection (c) to occur. The office of
37	Medicaid policy and planning shall use these appropriations and
38	transfers for purposes of IC 12-15-15-9(a) through

IC 12-15-15-9(d) for the state fiscal year beginning July 1, 2000,

(e) The state hospital care for the indigent fund shall close upon

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41 42 and ending June 30, 2001.

the earlier of the following:

1	(1) The payment of all funds in the fund.
2	(2) The payment of all claims for services provided before
3	July 1, 2002, that were eligible for payment under the hospital
4	care for the indigent program under IC 12-16 (before its
5	repeal).
6	(f) Notwithstanding subsection (e), if at any time before the
7	closing of the state hospital care for the indigent fund the amount
8	of funds on deposit exceeds the amount necessary to pay the claims
9	for services provided before July 1, 2002, that were eligible for
10	payment under the hospital care for the indigent program under
11	IC 12-16 (before its repeal), those excess funds shall be transferred
12	from the fund to the Medicaid program for use as the state's share
13	of funding for payments to hospitals under IC 12-15-15-9(a) and
14	IC 12-15-15-9(e).
15	(g) Upon the closing of the state hospital care for the indigent
16	fund, no further obligation shall be owed under the hospital care
17	for the indigent program under IC 12-16 (before its repeal).
18	Sec. 3. If the office of the uninsured parents program
19	established by IC 12-17.7-2-1 does not implement an uninsured
20	parents program before July 1, 2003, the amounts transferred
21	under this chapter to the state uninsured parents program fund
22	established by IC 12-17.8-2-1 shall be returned to the state hospital
23	care for the indigent fund.
24	SECTION 28. IC 12-16.1 IS ADDED TO THE INDIANA CODE
25	AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY
26	1, 2003]:
27	ARTICLE 16.1. HOSPITAL CARE FOR THE INDIGENT
28	Chapter 1. Applicability
29	Sec. 1. This article applies only if the office of the uninsured
30	parents program established by IC 12-17.7-2-1 does not implement
31	an uninsured parents program before July 1, 2003.
32	Chapter 2. Administration and General Provisions
33	Sec. 1. The division shall administer the hospital care for the
34	indigent program under this article.
35	Sec. 2. The division shall adopt necessary forms to be used by
36	the patients, hospitals, physicians, and county offices in carrying
37	out the hospital care for the indigent program.
38	Sec. 3. The following persons have the same rights and
39	obligations with respect to the hospital care for the indigent
40	program as the persons have with respect to the Medicaid program
41	under IC 12-15-8 and IC 12-15-29:



(1) The division.

1	(2) Applicants and recipients of assistance.
2	(3) Insurers.
3	(4) Persons against whom applicants and recipients of
4	assistance have claims.
5	(5) The office of Medicaid policy and planning.
6	Sec. 4. To the extent permitted under federal statutes or
7	regulations, patient days for patients under the hospital care for
8	the indigent program shall be included in calculating allowable
9	disproportionate share additional payments under 42 U.S.C.
10	1395ww(d).
11	Sec. 5. The hospital care for the indigent program does not
12	apply to inmates and patients of institutions of the department of
13	correction, the state department of health, the division of mental
14	health, or the division of disability, aging, and rehabilitative
15	services.
16	Chapter 3. Eligibility for Assistance
17	Sec. 1. (a) An Indiana resident who meets the income and
18	resource standards established by the division under section 3 of
19	this chapter is eligible for assistance to pay for any part of the cost
20	of care provided in a hospital in Indiana that was necessitated after
21	the onset of a medical condition that was manifested by symptoms
22	of sufficient severity that the absence of immediate medical
23	attention would probably result in any of the following:
24	(1) Placing the individual's life in jeopardy.
25	(2) Serious impairment to bodily functions.
26	(3) Serious dysfunction of a bodily organ or part.
27	(b) A qualified resident is also eligible for assistance to pay for
28	the part of the cost of care that is a direct consequence of the
29	medical condition that necessitated the emergency care.
30	Sec. 2. (a) An individual who is not an Indiana resident is
31	eligible for assistance to pay for the part of the cost of care
32	provided in a hospital in Indiana that was necessitated after the
33	onset of a medical condition that was manifested by symptoms of
34	sufficient severity that the absence of immediate medical attention
35	would probably result in any of the following:
36	(1) Placing the individual's life in jeopardy.
37	(2) Serious impairment to bodily functions.
38	(3) Serious dysfunction of any bodily organ or part.
39	(b) An individual is eligible for assistance under subsection (a)
40	only if the following qualifications exist:
41	(1) The individual meets the income and resource standards
42	established by the division under section 3 of this chapter.



1	(2) The onset of the medical condition that necessitated
2	medical attention occurred in Indiana.
3	Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to
4	establish income and resource eligibility standards for patients
5	whose care is to be paid for under the hospital care for the indigent
6	program.
7	(b) To the extent possible, rules adopted under this section must
8	meet the following conditions:
9	(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.
.0	(2) Be adjusted at least one (1) time every two (2) years.
. 1	(c) The income and eligibility standards established under this
2	section do not include any spend down provisions available under
.3	IC 12-15-21.
4	(d) In addition to the conditions imposed under subsection (b),
. 5	rules adopted under this section must exclude a Holocaust victim's
.6	settlement payment received by an eligible individual from the
7	income and eligibility standards for patients whose care is to be
.8	paid for under the hospital care for the indigent program.
9	Sec. 4. A hospital shall provide a patient and, if the patient is not
20	able to understand the statement, the patient's representative with
21	a statement of the eligibility and benefit standards adopted by the
22	division if at least one (1) of the following occurs:
23	(1) The hospital has reason to believe that the patient may be
24	indigent.
25	(2) The patient requests a statement of the standards.
26	Chapter 4. Application for Assistance
27	Sec. 1. To receive payment from the division for the costs
28	incurred in providing care to an indigent person, a hospital must
29	file an application with the county office of the county in which the
30	hospital is located.
31	Sec. 2. A hospital must file the application with a county office
32	not more than thirty (30) days after the patient has been admitted
33	to the hospital, unless the patient is medically unable to sign the
34	application and the next of kin or legal representative of the patient
35	is unavailable.
36	Sec. 3. The division shall adopt rules under IC 4-22-2
37	prescribing the following:
88	(1) The form of an application.
39	(2) The establishment of procedures for applications.
10	(3) The time for submitting and processing claims.
11	Sec. 4. The division and a county office shall make application
12	forms available to a hospital upon request.



1	Sec. 5. A hospital or an attending physician may assist the
2	patient in the preparation of an application for assistance under
3	the hospital care for the indigent program.
4	Sec. 6. A person who in good faith provides assistance in the
5	completion of an application under this chapter is immune from
6	civil or criminal liability arising from the assistance.
7	Sec. 7. (a) A patient must sign an application if the patient is
8	medically able to sign.
9	(b) If a patient is medically unable to sign an application, the
10	patient's next of kin or a legal representative of the patient, if
11	available, may sign the application.
12	(c) If no person under subsections (a) and (b) is able to sign the
13	application to file a timely application, a hospital representative
14	may sign the application instead of the patient.
15	Sec. 8. (a) A patient may file an application directly with the
16	county office in the county where the hospital providing care is
17	located if the application is filed not more than thirty (30) days
18	after the patient's admission to the hospital.
19	(b) Reimbursement for the costs incurred in providing care to
20	an eligible person may only be made to the providers of the care.
21	Chapter 5. Eligibility Determinations; Investigations
22	Sec. 1. A county office shall, upon receipt of an application of a
23	patient admitted to a hospital, promptly investigate to determine
24	the patient's eligibility under the hospital care for the indigent
25	program.
26	Sec. 2. (a) The hospital providing medical care to a patient shall
27	provide information the hospital has that would assist in the
28	verification of indigency of a patient.
29	(b) A hospital that provides information under subsection (a) is
30	immune from civil and criminal liability for divulging the
31	information.
32	Sec. 3. If the division or county office is unable, after prompt
33	and diligent efforts, to verify information contained in the
34	application that is reasonably necessary to determine eligibility, the
35	division or county office may deny assistance under the hospital
36	care for the indigent program.
37	Sec. 4. The division or county office shall notify, in writing, the
38	patient and the hospital of the following:
39	(1) A decision concerning eligibility.
40	(2) The reasons for a denial of eligibility.
41	(3) That either party has the right to appeal the decision.
42	Chapter 6. Denial of Eligibility; Appeals; Judicial Review



1	Sec. 1. If the division or county office determines that a patient
2	is not eligible for payment of medical or hospital care, an affected
3	person may appeal to the division not later than ninety (90) days
4	after the mailing of notice of that determination to the affected
5	person at the person's last known address.
6	Sec. 2. If the division or county office:
7	(1) fails to complete an investigation and determination of
8	eligibility under the hospital care for the indigent program
9	within forty-five (45) days after the receipt of the application
10	filed under IC 12-16.1-4; or
11	(2) fails or refuses to accept responsibility for payment of
12	medical or hospital care under the hospital care for the
13	indigent program;
14	a person affected may appeal to the division not more than ninety
15	(90) days after the receipt of the application filed under
16	IC 12-16.1-4.
17	Sec. 3. The division shall fix a time and place for a hearing
18	before a hearing officer appointed by the director of the division.
19	Sec. 4. A notice of the hearing shall be served upon all persons
20	interested in the matter at least twenty (20) days before the time
21	fixed for the hearing.
22	Sec. 5. (a) Following the hearing, the division shall determine the
23	eligibility of the person for payment of the cost of medical or
24	hospital care under the hospital care for the indigent program.
25	(b) If the person is found eligible, the division shall pay the
26	reasonable cost of the care to the persons furnishing the care,
27	subject to the limitations in IC 12-16.1-7.
28	Sec. 6. A person aggrieved by a determination under section 5(a)
29	of this chapter may appeal the determination under IC 4-21.5.
30	Sec. 7. (a) The division shall adopt rules under IC 4-22-2 that
31	provide for an administrative appeal procedure that is responsive
32	to the needs of patients and providers.
33	(b) The procedure must provide for the following:
34	(1) The location of hearings.
35	(2) The presentation of evidence.
36	(3) The use of telecommunications.
37	Chapter 7. Cost of Care and Payment
38	Sec. 1. The division shall pay the following, subject to the
39	limitations in section 4 of this chapter:
40	(1) The necessary costs of medical or hospital care for
41	indigent patients.
42	(2) The cost of transportation to the place of treatment arising



1	out of the medical or hospital care for indigent patients.
2	Sec. 2. (a) Except as provided in section 5 of this chapter, claims
3	for payment shall be segregated by year using the patient's
4	admission date.
5	(b) Each year, the division shall pay claims as provided in
6	section 4 of this chapter without regard to the county of admission
7	or that county's transfer to the state fund.
8	Sec. 3. A payment made to a hospital under the hospital care for
9	the indigent program must be on a warrant drawn on the state
10	hospital care for the indigent fund established under IC 12-16-14.
11	Sec. 4. (a) Each year, the division shall pay two-thirds (2/3) of
12	each claim upon submission and approval of the claim.
13	(b) If the amount of money in the state hospital care for the
14	indigent fund in a year is insufficient to pay two-thirds $(2/3)$ of each
15	approved claim for patients admitted in that year, the state's and
16	a county's liability to providers under the hospital care for the
17	indigent program for claims approved for patients admitted in that
18	year is limited to the sum of the following:
19	(1) The amount transferred to the state hospital care for the
20	indigent fund from county hospital care for the indigent funds
21	in that year under IC 12-16.1-14.
22	(2) Any contribution to the fund in that year.
23	(3) Any amount that was appropriated to the state hospital
24	care for the indigent fund for that year by the general
25	assembly.
26	(4) Any amount that was carried over to the state hospital
27	care for the indigent fund from a preceding year.
28	(c) This section does not obligate the general assembly to
29	appropriate money to the state hospital care for the indigent fund.
30	Sec. 5. Before the end of each state fiscal year, the division shall,
31	to the extent there is money in the state hospital care for the
32	indigent fund, pay each provider under the hospital care for the
33	indigent program a pro rata part of the one-third $(1/3)$ balance on
34	each approved claim for patients admitted during the preceding
35	year.
36	Sec. 6. If:
37	(1) a claim for a patient admitted during a particular year is
38	not submitted by the deadline established by the division; and
39	(2) the failure to submit the claim is not the fault of the
40	provider;
41	the claim shall be considered a claim for the year the claim is

submitted for purposes of payment under this chapter.



1	Sec. 7. The division and a county office are not responsible
2	under the hospital care for the indigent program for the payment
3	of any part of the costs of providing care in a hospital to an
4	individual who is not either of the following:
5	(1) A citizen of the United States.
6	(2) A lawfully admitted alien.
7	Sec. 8. The division and a county office are not liable for any
8	part of the cost of care provided to an individual who has been
9	determined to be a patient described in the rules adopted under
10	IC 12-16.1-10.
11	Sec. 9. IC 12-16.1-2 through IC 12-16.1-16 do not affect the
12	liability of a county with respect to claims for hospital care for the
13	indigent for patients admitted before January 1, 1987.
14	Sec. 10. (a) The budget agency shall estimate for each fiscal year
15	the cost savings to the state hospital care for the indigent fund as
16	the result of the provision of Medicaid to an individual described
17	in IC 12-15-2-12 and IC 12-15-2-13.
18	(b) The budget agency shall, each fiscal year, recommend to the
19	general assembly that an amount equal to the cost savings
20	described in subsection (a) be transferred from the state hospital
21	care for the indigent fund to the state general fund.
22	Sec. 11. Providers eligible for payment under IC 12-15-15-9 may
23	not receive payment under this chapter.
24	Sec. 12. All providers receiving payment under this chapter
25	agree to accept, as payment in full, the amount paid for the hospital
26	care for the indigent program for those claims submitted for
27	payment under the program, with the exception of authorized
28	deductibles, co-insurance, co-payment, or similar cost sharing
29	charges.
30	Chapter 8. Disproportionate Share Providers
31	Sec. 1. As used in this chapter, "inpatient days" includes:
32	(1) days provided by an acute care subunit of the provider;
33	and
34	(2) inpatient days attributable to Medicaid and hospital care
35	for the indigent beneficiaries from other states.
36	Sec. 2. A payment adjustment consisting of an additional
37	percentage payment for each service paid under the hospital care
38	for the indigent program made to a disproportionate share hospital
39	licensed under IC 16-21 that meets the requirements under section
40	3 of this chapter.
41	Sec. 3. A provider is a disproportionate share hospital if the
42	provider's Medicaid inpatient utilization rate is at least one (1)



1	standard deviation above the mean Medicaid inpatient utilization
2	rate for providers receiving Medicaid payments in Indiana.
3	Sec. 4. A provider's Medicaid inpatient utilization rate is a
4	fraction (expressed as a percentage) in which:
5	(1) the numerator is the provider's total number of Medicaid
6	and health care for the indigent inpatient days in a cost
7	reporting period; and
8	(2) the denominator is the total number of the provider's
9	inpatient days in that same period.
.0	Sec. 5. A disproportionate share hospital must receive a twenty
.1	percent (20%) adjustment for each service.
2	Chapter 9. Rate of Payment
.3	Sec. 1. The rate of payment for the services and materials
4	provided by hospitals and physicians under the hospital care for
.5	the indigent program is the same rate as payment for the same type
6	of services and materials under the rules adopted by the secretary
.7	under Medicaid.
8	Chapter 10. Rules
9	Sec. 1. The division shall, with the advice of the division's
20	medical staff, the division of mental health, the division of
21	disability, aging, and rehabilitative services, and other individuals
22	selected by the director of the division, adopt rules under IC 4-22-2
23	to do the following:
24	(1) Provide for review and approval of services paid under the
25	hospital care for the indigent program.
26	(2) Establish limitations consistent with medical necessity on
27	the duration of services to be provided.
28	(3) Specify the amount of and method for reimbursement for
29	services.
30	(4) Specify the conditions under which payments will be
31	denied and improper payments will be recovered.
32	Sec. 2. To the extent possible, rules adopted under section 1 of
33	this chapter must be consistent with IC 12-15-21-2 and
34	IC 12-15-21-3.
35	Sec. 3. The rules adopted under section 1 of this chapter must
36	include rules that will deny payment for services provided to a
37	patient after the patient is medically stable and can safely be
88	discharged.
39	Sec. 4. (a) The division shall adopt rules under IC 4-22-2
10	necessary to establish a statewide collection system of data
11	concerning the hospital care for the indigent program.
12	(b) The following data must be collected:



1	(1) Patient demographics.
2	(2) Types of services provided by hospitals.
3	(3) Costs of particular types of services provided by hospitals.
4	(c) A hospital that provides services under the hospital care for
5	the indigent program shall file copies of all claims submitted under
6	the program with the contractor engaged by the division to
7	adjudicate claims.
8	Sec. 5. The division may adopt rules under IC 4-22-2 that are in
9	addition to and consistent with the rules required to be adopted
10	under IC 12-16.1-6 governing appeals brought under the hospital
11	care for the indigent program to the division.
12	Chapter 11. Recovery of Payments by Division
13	Sec. 1. The division may recover amounts paid under the
14	hospital care for the indigent program by the division from the
15	following:
16	(1) A patient approved for assistance.
17	(2) A person legally responsible for those patients approved
18	for assistance.
19	(3) The estate of the patient or person.
20	Sec. 2. The division is subrogated, to the extent of the assistance
21	given by the division, to the rights that a patient receiving
22	assistance under the hospital care for the indigent program has
23	against any other person who is in any part liable for the illness or
24	injury for which assistance was granted.
25	Chapter 12. County With Health and Hospital Corporation;
26	Responsibility for Medical Cost
27	Sec. 1. This chapter applies to a county having a health and
28	hospital corporation created under IC 16-22-8-6.
29	Sec. 2. The division is responsible for the emergency medical
30	care given in a hospital to an individual who qualifies for assistance
31	under this chapter, subject to the limitations in IC 12-16.1-7.
32	Sec. 3. The hospital providing care shall transfer the patient to
33	a hospital operated by the health and hospital corporation as soon
34	as the attending physician determines that the patient's medical
35	condition permits the transfer without risk of injury to the patient.
36	Sec. 4. (a) If a hospital owned by the health and hospital
37	corporation is:
38	(1) unable to care for a patient; or
39	(2) unable to treat a patient at the time a transfer is requested
40	by the hospital initiating treatment;
41	the hospital initiating treatment may continue to treat the patient
42	until the patient's discharge.



1	(b) Subject to the limitations in IC 12-16.1-7, the division shall
2	pay the costs of care.
3	Sec. 5. The division is not responsible for the following:
4	(1) The payment of nonemergency medical costs, except as
5	provided under the hospital care for the indigent program.
6	(2) The payment of medical costs accrued at a hospital owned
7	or operated by a health and hospital corporation, except for
8	hospital care provided under this chapter to a person not
9	residing in Marion County.
10	Chapter 13. Immunity
11	Sec. 1. A hospital, a physician, or an agent or employee of a
12	hospital or physician that provides services in good faith under the
13	hospital care for the indigent program is immune from liability to
14	the extent the liability is attributable to at least one (1) of the
15	following:
16	(1) The requirement that a patient be transferred under
17	IC 12-16.1-12.
18	(2) The denial of payment under IC 12-16.1-10.
19	Sec. 2. Section 1(1) of this chapter does not limit liability for the
20	determination that the patient's medical condition permits a
21	transfer under IC 12-16.1-12.
22	Chapter 14. Property Tax Levy and Funds
23	Sec. 1. A county hospital care for the indigent fund is established
24	in each county. The fund consists of the following:
25	(1) A tax levy on the property located in each county.
26	(2) The financial institutions tax (IC 6-5.5), motor vehicle
27	excise taxes (IC 6-6-5), and commercial vehicle excise taxes
28	(IC 6-6-5.5) that are allocated to the fund.
29	Sec. 2. (a) The tax required by section 1(1) of this chapter shall
30	be imposed annually by the county fiscal body on all of the taxable
31	property of the county.
32	(b) The tax shall be collected as other state and county ad
33	valorem property taxes are collected.
34	Sec. 3. Each county shall impose a hospital care for the indigent
35	tax levy equal to the product of:
36	(1) the most recent hospital care for the indigent property tax
37	levied by the county; multiplied by
38	(2) the statewide average assessed value growth quotient,
39	using all the county assessed value growth quotients
40	determined under IC 6-1.1-18.5-2 for the year in which the tax
41	levy under this section will be first due and payable.
42	Sec. 4. The state board of tax commissioners shall review each



1	county's property tax levy under this chapter and shall enforce the
2	requirements of this chapter with respect to that levy.
3	Sec. 5. All receipts derived from the tax levy shall be paid into
4	the county general fund and constitute the county hospital care for
5	the indigent fund.
6	Sec. 6. (a) The state hospital care for the indigent fund is
7	established.
8	(b) Before the fifth day of each month, all money contained in a
9	county hospital care for the indigent fund at the end of the
10	preceding month shall be transferred to the state hospital care for
11	the indigent fund.
12	Sec. 7. (a) The state hospital care for the indigent fund consists
13	of the following:
14	(1) Money transferred to the state hospital care for the
15	indigent fund from the county hospital care for the indigent
16	funds.
17	(2) Any contributions to the fund from individuals,
18	corporations, foundations, or others for the purpose of
19	providing hospital care for the indigent.
20	(3) Money advanced to the fund under IC 12-16.1-15.
21	(4) Appropriations made specifically to the fund by the
22	general assembly.
23	(b) This section does not obligate the general assembly to
24	appropriate money to the state hospital care for the indigent fund.
25	Sec. 8. The division shall administer the state hospital care for
26	the indigent fund and shall use the money currently in the fund to
27	defray the expenses and obligations incurred by the division for
28	hospital care for the indigent. The money in the fund is hereby
29	appropriated.
30	Sec. 9. Money in the state hospital care for the indigent fund at
31	the end of a state fiscal year remains in the fund and does not
32	revert to the state general fund.
33	Chapter 15. Advancements From State Fund
34	Sec. 1. The division may request an advancement of money from
35	the state general fund in anticipation of county property tax
36	revenue being transferred to the state hospital care for the indigent
37	fund.
38	Sec. 2. (a) The budget director shall determine an interest rate
39	that is at least the interest rate earned by the state on investments
40	made from money in the state general fund.
41	(b) The interest rate shall be paid on the amount that is
42	advanced from the state general fund.



1	Sec. 3. The amount that may be advanced, plus the projected
2	interest on that amount, may not exceed the amount of county
3	property tax revenue that is expected to be transferred to the state
4	hospital care for the indigent fund during the six (6) months
5	following the date of the request.
6	Sec. 4. A request for an advancement must be submitted to the
7	budget agency.
8	Sec. 5. The state board of finance may, on the recommendation
9	of the director of the budget agency, approve an advancement.
10	Sec. 6. If an advancement is approved, the county property tax
11	revenue transferred to the state hospital care for the indigent fund
12	shall be immediately used to repay the amount of the interest and
13	advancements made under this section.
14	Chapter 16. Review of Medical Criteria
15	Sec. 1. The division shall review changes made after 1985 in the
16	medical criteria used to establish whether a patient is eligible for
17	assistance under IC 12-16.1-3.
18	Sec. 2. The division's review under this chapter must include the
19	application of the criteria to specific cases and address whether
20	changes to or clarification of the criteria is necessary so that, in
21	practice, the criteria are consistent with the hospital care for the
22	indigent program.
23	Sec. 3. The division shall provide to an interested party a report
24	of the division's review, including the division's findings,
25	conclusions, and recommendations.
26	SECTION 29. IC 12-17.7 IS ADDED TO THE INDIANA CODE
27	AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE
28	JANUARY 1, 2002]:
29	ARTICLE 17.7. UNINSURED PARENTS PROGRAM
30	Chapter 1. Definitions
31	Sec. 1. The definitions in this chapter apply throughout this
32	article.
33	Sec. 2. (a) "Caretaker relative" means a blood relative and those
34	of half blood.
35	(b) The term includes an adoptive parent, grandparent, sibling,
36	and a relative of an adoptive parent.
37	(c) The term also includes a spouse of an individual described in
38	subsection (b), even after the marriage is terminated by death or
39	dissolution.
40	Sec. 3. "Crowd out" means the extent to which:
41	(1) an individual substitutes coverage offered under the
42	program for employer sponsored health insurance coverage;



1	or	
2	(2) employers:	
3	(A) reduce or eliminate health insurance benefits under an	
4	employer based health insurance plan; or	
5	(B) increase the employee's share of the cost of benefits	
6	under an employer based health insurance plan relative to	
7	the total cost of the plan;	
8	as a result of the program.	
9	Sec. 4. "Office" refers to the office of the uninsured parents	
10	program established by IC 12-17.7-2-1.	
11	Sec. 5. "Program" refers to the uninsured parents program	
12	established under IC 12-17.7-2-2.	
13	Chapter 2. Program Administration	
14	Sec. 1. The office of the uninsured parents program is	
15	established within the office of the secretary.	
16	Sec. 2. The office shall design and administer a system to	
17	provide health benefits coverage for individuals eligible for the	
18	program.	
19	Sec. 3. To the greatest extent possible, the office shall use the	
20	same:	
21	(1) eligibility determination;	
22	(2) enrollment;	
23	(3) provider networks; and	
24	(4) claims payment systems;	
25	as are used by the Medicaid managed care program for adults.	
26	Sec. 4. Reviews of the program by the office must:	
27	(1) be conducted in compliance with federal requirements;	
28	and	
29	(2) include an analysis of the extent to which crowd out is	
30	occurring.	
31	Sec. 5. The office shall do the following:	
32	(1) Establish performance criteria and evaluation measures.	
33	(2) Monitor program performance.	
34	(3) Adopt a formula for establishing the number of eligible	
35	individuals to be enrolled in the program, taking into	
36	consideration the following:	
37	(A) The cost of establishing and maintaining the program.	
38	(B) The number of eligible individuals.	
39	(C) The fact that the program is not an entitlement	
40	program.	
41	(4) Adopt a methodology for enrolling eligible individuals,	
12	taking into consideration the fact that the program is not an	



1	entitlement program.
2	Sec. 6. The office may, in administering the program, contract
3	with community entities, including private entities, for the
4	following:
5	(1) Outreach for and enrollment in the program.
6	(2) Provision of services.
7	(3) Consumer education and public health education.
8	Sec. 7. (a) The office shall adopt rules under IC 4-22-2 to
9	implement the program.
0	(b) The office may adopt emergency rules under IC 4-22-2-37.1
.1	to implement the program on an emergency basis.
2	Sec. 8. Not later than April 1 of each year, the office shall
.3	provide a report describing the program's activities during the
4	preceding calendar year to the following:
.5	(1) Budget committee.
6	(2) Legislative council.
.7	(3) Select joint committee on Medicaid oversight.
. 8	Chapter 3. Eligibility, Outreach, and Enrollment
9	Sec. 1. (a) To be eligible to enroll in the program, an individual
20	must meet the following requirements:
21	(1) The individual is:
22	(A) at least nineteen (19); and
23	(B) less than sixty-five (65);
24	years of age.
25	(2) The individual is a caretaker relative of at least one (1)
26	child in a family with an annual income of:
27	(A) at least twenty-six percent (26%); and
28	(B) not more than one hundred percent (100%);
29	of the federal income poverty level.
30	(3) The child described in subdivision (2) is enrolled in the
31	Medicaid managed care program for children or another
32	Medicaid program that is otherwise appropriate for the
33	child's age and medical condition.
34	(4) The individual resides on a full-time basis with the family
35	described in subdivision (2).
86	(5) The individual is a resident of Indiana.
37	(b) The office may adopt rules under IC 4-22-2 to adjust
88	eligibility requirements based on available program resources.
39	Sec. 2. (a) Subject to subsection (b), an individual who is eligible
10	for the program shall receive services from the program until the
1	earlier of the following:
12	(1) The end of a period of twelve (12) consecutive months



1	following the determination of the individual's eligibility for
2	the program.
3	(2) The individual becomes eligible for enrollment, or would
4	be eligible for enrollment if the individual were not enrolled
5	in the uninsured parents program, in any other:
6	(A) Medicaid program; or
7	(B) health care program administered by local, state, or
8	federal government.
9	(3) The individual no longer resides on a full-time basis with
0	the family whose income served as the basis for the
1	individual's eligibility for the program.
2	(4) The individual becomes sixty-five (65) years of age.
3	(b) Subsection (a) applies only if the individual complies with
4	the program's enrollment requirements.
.5	Sec. 3. The office shall implement outreach strategies that build
6	on community resources.
.7	Sec. 4. An individual may apply at an enrollment center as
8	provided in IC 12-15-4-1 to receive health care services from the
9	program if the individual meets the eligibility requirements of
20	section 1 of this chapter.
21	Chapter 4. Benefits, Crowd Out, and Cost Sharing
22	Sec. 1. The benefit package provided under the program must
23	focus on age appropriate preventive, primary, and acute care
24	services.
25	Sec. 2. The office shall offer health insurance coverage for the
26	following basic services:
27	(1) Inpatient and outpatient hospital services.
28	(2) Physicians' services provided by a physician (as defined in
29	42 U.S.C. $1395x(r)$).
30	(3) Laboratory and x-ray services.
31	(4) Emergency medical services.
32	Sec. 3. The office may offer services in addition to those
33	described in section 2 of this chapter if funds for the program exist
34	to pay for the additional services.
35	Sec. 4. (a) The office shall offer health insurance coverage for
86	the following additional services if the coverage for the services has
37	an actuarial value equal to or greater than the actuarial value of
88	the services provided by the benchmark program determined by
19	the children's health policy board established by IC 4-23-27-2:
10	(1) Prescription drugs.
11	(2) Mental health services.
12	(3) Vision services.



1	(4) Hearing services.
2	(5) Dental services.
3	(b) The office may not impose treatment limitations or financial
4	requirements on the coverage of services for a mental illness if
5	similar treatment limitations or financial requirements are not
6	imposed on coverage for services for other illnesses.
7	Sec. 5. The office may not impose premiums, deductibles,
8	coinsurance, or other cost sharing upon enrollees in the program.
9	Sec. 6. The office may do the following:
10	(1) Determine waiting periods that may not exceed three (3)
11	months and exceptions to the requirement of waiting periods
12	for potential enrollees in the program.
13	(2) Adopt additional methods for complying with any federal
14	requirements relating to crowd out.
15	Chapter 5. Provider Contracts
16	Sec. 1. A provider agreement must include information that the
17	office finds necessary to facilitate carrying out this article.
18	Sec. 2. A provider who participates in the program must comply
19	with the enrollment requirements established under IC 12-15.
20	Sec. 3. A provider who participates in the Medicaid program is
21	considered a provider for both the Medicaid program and the
22	program under this article.
23	Sec. 4. A provider:
24	(1) who participates in the Medicaid managed care program
25	for children; and
26	(2) whose practice is not limited to the care and treatment of
27	children only;
28	is considered a provider for both the Medicaid program and the
29	program under this article.
30	Sec. 5. If an enrollee in the Medicaid managed care program for
31	children has direct access to a provider:
32	(1) who has entered into a provider agreement under
33	IC 12-15-11; and
34	(2) whose practice is not limited to the care and treatment of
35	children only;
36	an enrollee in the uninsured parents program shall have direct
37	access to the same provider.
38	Chapter 6. Appeals and Hearings
39	Sec. 1. An applicant for or a recipient of services under the
40	program may appeal to the office if any of the following occurs:
41	(1) An application or a request is not acted upon by the office
42	within a reasonable time after the application or request is



1	filed.
2	(2) The application is denied.
3	(3) The applicant or recipient is dissatisfied with the action of
4	the office.
5	Sec. 2. The secretary shall conduct hearings and appeals
6	concerning the program under IC 4-21.5.
7	Sec. 3. The office shall, upon receipt of notice of an appeal under
8	section 1 of this chapter, set the matter for hearing and give the
9	applicant or recipient an opportunity for a fair hearing in the
10	county in which the applicant or recipient resides.
11	Sec. 4. (a) At a hearing held under section 3 of this chapter, the
12	applicant or recipient and the office may introduce additional
13	evidence.
14	(b) A hearing held under section 3 of this chapter shall be
15	conducted under rules adopted by the secretary for applicants and
16	recipients of Medicaid that are not inconsistent with IC 4-21.5 and
17	the program.
18	Sec. 5. The office:
19	(1) may make necessary additional investigations; and
20	(2) shall make decisions concerning the:
21	(A) granting of program services; and
22	(B) amount of program services to be granted;
23	to an applicant or a recipient that the office believes are
24	justified and in conformity with the program.
25	Chapter 7. Confidentiality and Release of Information
26	Sec. 1. The following concerning a program applicant or
27	recipient under the program are confidential, except as otherwise
28	provided in this chapter:
29	(1) An application.
30	(2) An investigation report.
31	(3) An information.
32	(4) A record.
33	Sec. 2. The use and the disclosure of the information described
34	in this chapter to persons authorized by law in connection with the
35	official duties relating to:
36	(1) financial audits;
37	(2) legislative investigations; or
38	(3) other purposes directly connected with the administration
39	of the program;
40	is authorized.
41	Sec. 3. (a) The release and use of information of a general nature
42	shall be provided as needed for adequate interpretation or



1	development of the program.
2	(b) The information described in subsection (a) includes the
3	following:
4	(1) Total program expenditures.
5	(2) The number of recipients.
6	(3) Statistical and social data used in connection with studies.
7	(4) Reports or surveys on health and welfare problems.
8	Sec. 4. The office shall make available the following to providers
9	for immediate access to information indicating whether an
10	individual is eligible for the program:
11	(1) A twenty-four (24) hour telephone system.
12	(2) A computerized data retrieval system.
13	Sec. 5. Information released under section 4 of this chapter is
14	limited to the following:
15	(1) Disclosure of whether an individual is eligible for the
16	program.
17	(2) The date the individual became eligible for the program
18	and the individual's program number.
19	(3) Restrictions, if any, on the scope of services to be
20	reimbursed under the program for the individual.
21	Sec. 6. Information obtained by a provider under this chapter
22	concerning an individual's eligibility for the program is
23	confidential and may only be disclosed to the following:
24	(1) Another provider involved or potentially involved in the
25	care of the individual.
26	(2) A person who:
27	(A) works under the authority of a provider described in
28	subdivision (1); and
29	(B) requires the information for the provider's legitimate
30	business or clinical purposes.
31	Sec. 7. If it is established that a provision of this chapter causes
32	the program to be ineligible for federal financial participation, the
33	provision is limited or restricted to the extent that is essential to
34	make the program eligible for federal financial participation.
35	SECTION 30. IC 12-17.8 IS ADDED TO THE INDIANA CODE
36	AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY
37	1, 2001]:
38	ARTICLE 17.8. FUNDING OF UNINSURED PARENTS
39	PROGRAM
40	Chapter 1. County Uninsured Parents Program Funds
41	Sec. 1. This chapter applies beginning July 1, 2002.
42	Sec. 2. (a) A county uninsured parents program fund is



1	established in each county. The fund consists of the following:
2	(1) A tax levy on the property located in each county.
3	(2) The financial institutions tax (IC 6-5.5), motor vehicle
4	excise taxes (IC 6-6-5), and commercial vehicle excise taxes
5	(IC 6-6-5.5) that are allocated to the fund.
6	(b) A county's uninsured parents program fund replaces the
7	county's hospital care for the indigent fund under IC 12-16-14-1
8	(before its repeal).
9	(c) The methodology for allocating taxes under subsection (a)(2)
10	to a county uninsured parents program fund shall be the same as
11	the methodology used for allocating taxes to the county's hospital
12	care for the indigent fund under IC 12-16-14-1 (before its repeal).
13	Sec. 3. (a) The tax required by section 2(a)(1) of this chapter
14	shall be imposed annually by the county fiscal body on all the
15	taxable property of the county.
16	(b) The tax shall be collected as other state and county ad
17	valorem property taxes are collected.
18	(c) The initial levy under section 2(a)(1) of this chapter shall
19	occur on the same date following July 1, 2002, that the levy under
20	IC 12-16-14-1(1) (before its repeal) would have next occurred.
21	Sec. 4. Except as provided in sections 5 and 6 of this chapter,
22	each county shall impose an uninsured parents program property
23	tax levy equal to the product of:
24	(1) for the initial levy imposed under this chapter after July 1,
25	2002:
26	(A) a levy equal ninety percent (90%) of to the hospital
27	care for the indigent property tax levy imposed in calendar
28	year 2001 for taxes first due and payable in calendar year
29	2002; multiplied by
30	(B) the statewide average assessed value growth quotient,
31	using all the county assessed value growth quotients
32	determined under IC 6-1.1-18.5-2 for the year in which the
33	tax levy under this subdivision will be first due and
34	payable;
35	(2) for the second annual levy imposed under this chapter:
36	(A) a levy equal ninety percent (90%) of to the hospital
37	care for the indigent property tax levy imposed in calendar
38	year 2002 for taxes first due and payable in calendar year
39	2003; multiplied by
40	(B) the statewide average assessed value growth quotient,
41	using all the county assessed value growth quotients
42	determined under IC 6-1.1-18.5-2 for the year in which the



1	tax levy under this subdivision will be first due and
2	payable; and
3	(3) for all subsequent annual levies imposed under this
4	chapter:
5	(A) a levy equal to the uninsured parents program
6	property tax levy imposed for taxes first due and payable
7	in the preceding year; multiplied by
8	(B) the statewide average assessed value growth quotient,
9	using all the county assessed value growth quotients
10	determined under IC 6-1.1-18.5-2 for the year in which the
11	tax levy under this subdivision will be first due and
12	payable.
13	Sec. 5. A county having a population of at least four hundred
14	thousand (400,000) but less than seven hundred thousand (700,000)
15	shall impose an uninsured parents program property tax levy
16	equal to the product of:
17	(1) for the initial levy imposed under this chapter following
18	July 1, 2002, a levy equal to:
19	(A) the difference between:
20	(i) the hospital care for the indigent property tax levy
21	imposed in calendar year 2001 for taxes first due and
22	payable in calendar year 2002; minus
23	(ii) four million dollars (\$4,000,000); multiplied by
24	(B) the statewide average assessed value growth quotient,
25	using all the county assessed value growth quotients
26	determined under IC 6-1.1-18.5-2 for the year in which the
27	tax levy under this subdivision will be first due and
28	payable;
29	(2) for the second annual levy imposed under this chapter, a
30	levy equal to:
31	(A) the difference between:
32	(i) the hospital care for the indigent property tax levy
33	imposed in calendar year 2002 for taxes first due and
34	payable in calendar year 2003; minus
35	(ii) four million dollars (\$4,000,000); multiplied by
36	(B) the statewide average assessed value growth quotient,
37	using all the county assessed value growth quotients
38	determined under IC 6-1.1-18.5-2 for the year in which the
39	tax levy under this subdivision will be first due and
40	payable; and
41	(3) for all subsequent impositions of the levy, the amount that
42	results from the calculation under section 4(3) of this chapter.



1	Sec. 6. A county having a population of at least two hundred
2	thousand (200,000) but less than three hundred thousand (300,000)
3	shall impose an uninsured parents program property tax levy
4	equal to the product of:
5	(1) for the initial levy imposed under this chapter following
6	July 1, 2002, a levy equal to:
7	(A) the difference between:
8	(i) the hospital care for the indigent property tax levy
9	imposed in calendar year 2001 for taxes first due and
10	payable in calendar year 2002; minus
11	(ii) one million dollars (\$1,000,000); multiplied by
12	(B) the statewide average assessed value growth quotient,
13	using all the county assessed value growth quotients
14	determined under IC 6-1.1-18.5-2 for the year in which the
15	tax levy under this subdivision will be first due and
16	payable;
17	(2) for the second annual levy imposed under this chapter, a
18	levy equal to:
19	(A) the difference between:
20	(i) the hospital care for the indigent property tax levy
21	imposed in calendar year 2002 for taxes first due and
22	payable in calendar year 2003; minus
23	(ii) one million dollars (\$1,000,000); multiplied by
24	(B) the statewide average assessed value growth quotient,
25	using all the county assessed value growth quotients
26	determined under IC 6-1.1-18.5-2 for the year in which the
27	tax levy under this subdivision will be first due and
28	payable; and
29	(3) for all subsequent impositions of the levy, the amount that
30	results from the calculation under section 4(3) of this chapter.
31	Sec. 7. The state board of tax commissioners shall review each
32	county's property tax levy under this chapter and shall enforce the
33	requirements of this chapter with respect to that levy.
34	Sec. 8. All receipts derived from the tax levy shall be paid into
35	the county general fund and constitute the county uninsured
36	parents program fund.
37	Chapter 2. State Uninsured Parents Program Fund
38	Sec. 1. (a) The state uninsured parents program fund is
39	established.
40	(b) Before the fifth day of each month, all money contained in a
41	county uninsured parents program fund at the end of the
42	preceding month shall be transferred to the state uninsured



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1	parents program fund.
2	Sec. 2. (a) The state uninsured parents program fund consists of
<i>3</i>	the following:
	(1) The money transferred to the state uninsured parents
5	program fund from the county uninsured parents program funds.
6	
7 8	(2) The money transferred to the state uninsured parents
9	program fund under IC 12-15-20-2(5).
	(3) The money transferred to the state uninsured parents
10	program fund under IC 12-16-14.1.
11 12	(4) Any contributions to the fund from individuals,
13	corporations, foundations, public or private trust funds, or
14	others for the purpose of providing medical assistance to
	uninsured parents.
15	(5) The money advanced to the fund under section 5 of this
16 17	chapter.
18	(6) The appropriations made specifically to the fund by the
19	general assembly or a state board, trust, or fund.
	(7) Any intergovernmental transfer from any source.
20	(b) This section does not obligate the general assembly or any
21	state board, trust, or fund to appropriate money to the state
22 23	uninsured parents program fund.
	Sec. 3. The office of the uninsured parents program established
24	by IC 12-17.7-2-1 shall administer the state uninsured parents
25	program fund and shall use the money in the fund to defray the
26	expenses and obligations incurred by the office for providing
27	medical services covered by the program. The money in the fund
28	is hereby appropriated.
29	Sec. 4. (a) Money in the state uninsured parents program fund
30	at the end of a state fiscal year remains in the fund and does not
31 32	revert to the state general fund. (b) For each state fixed year beginning July 1, 2002, the office
33	(b) For each state fiscal year beginning July 1, 2002, the office
33 34	of the uninsured parents program established by IC 12-17.7-2-1
	shall transfer from the state uninsured parents program fund an
35 36	amount equal to the amount determined by multiplying thirty-five
37	million dollars (\$35,000,000) by the federal medical assistance
	percentage for the state fiscal year. The transferred amount shall
38 39	be used for Medicaid current obligations. The transfer may be
	made in a single payment or multiple payments throughout the
40	state fiscal year.
41	Sec. 5. (a) The office of the uninsured parents program

established by IC 12-17.7-2-1 may request an advancement of



1	money from the state general fund in anticipation of county
2	property tax revenue being transferred to the state uninsured
3	parents program.
4	(b) The director of the budget agency shall determine an interest
5	rate that is at least the interest rate earned by the state on
6	investments made from money in the general fund and the rate so
7	determined by the director of the budget agency shall be paid on
8	the amount that is advanced from the state general fund.
9	(c) The amount that may be advanced, plus the projected
10	interest on that amount, may not exceed the amount of county
11	property tax revenue that is expected to be transferred to the state
12	uninsured parents program fund during the six (6) months
13	following the date of the request.
14	(d) A request for an advancement must be submitted to the
15	budget agency.
16	(e) The state board of finance may, on the recommendation of
17	the director of the budget agency, approve an advancement.
18	(f) If an advancement is approved, the county property tax
19	revenue transferred to the state uninsured parents program fund
20	shall be immediately used to repay the amount of the interest and
21	advancements made under this section.
22	Sec. 6. The treasurer of state shall invest the money in the state
23	uninsured parents program fund not currently needed to meet the
24	obligations of the fund in the same manner as other public funds
25	may be invested.
26	SECTION 31. IC 34-30-2-45.5 IS ADDED TO THE INDIANA
27	CODE AS A NEW SECTION TO READ AS FOLLOWS
28	[EFFECTIVE JUNE 30, 2002]: Sec. 45.5. IC 12-16.1-4-6 (Concerning
29	persons who aid a patient in completing an application for
30	assistance under the hospital care for the indigent program).
31	SECTION 32. IC 34-30-2-45.7 IS ADDED TO THE INDIANA
32	CODE AS A NEW SECTION TO READ AS FOLLOWS
33	[EFFECTIVE JUNE 30, 2002]: Sec. 45.7. IC 12-16.1-5-2 (Concerning
34	hospitals for providing information verifying indigency of patient).
35	SECTION 33. IC 34-30-2-45.9 IS ADDED TO THE INDIANA
36	CODE AS A NEW SECTION TO READ AS FOLLOWS
37	[EFFECTIVE JUNE 30, 2002]: Sec. 45.9. IC 12-16.1-13-1
38	(Concerning hospitals or persons providing services under the
39	hospital care for the indigent program).

SECTION 34. IC 35-43-5-7.3 IS AS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: **Sec. 7.3. (a) Except as provided**



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1	in subsection (b), a person who knowingly or intentionally:
2	(1) files an uninsured parents program claim, including an
3	electronic claim, in violation of IC 12-17.7;
4	(2) obtains payment from the uninsured parents program
5	under IC 12-17.7 by means of a false or misleading oral or
6	written statement or other fraudulent means;
7	(3) acquires a provider number under the uninsured parents
8	program except as authorized by law;
9	(4) alters with intent to defraud or falsifies documents or
.0	records of a provider (as defined in 42 CFR 1002.301) that are
.1	required to be kept under the uninsured parents program; or
.2	(5) conceals information for the purpose of applying for or
.3	receiving unauthorized payments from the uninsured parents
.4	program;
.5	commits insurance fraud, a Class D felony.
.6	(b) The offense described in subsection (a) is a Class C felony if
.7	the fair market value of the offense is at least one hundred
.8	thousand dollars (\$100,000).
.9	SECTION 35. IC 12-10-12-27.1; IC 12-10-12-28.5
20	IC 12-15-19-10.1 IS REPEALED [EFFECTIVE JULY 1, 2001].
21	SECTION 36. IC 12-17.6-1-2.6 IS REPEALED [EFFECTIVE
22	JANUARY 1, 2002].
23	SECTION 37. THE FOLLOWING ARE REPEALED [EFFECTIVE
24	JULY 1, 2002]: IC 12-7-2-118; IC 12-16-2; IC 12-16-3; IC 12-16-4;
25	IC 12-16-5; IC 12-16-6; IC 12-16-7; IC 12-16-8; IC 12-16-9;
26	IC 12-16-10; IC 12-16-11; IC 12-16-12; IC 12-16-13; IC 12-16-15;
27	IC 12-16-16; IC 34-30-2-44; IC 34-30-2-45; IC 34-30-2-45.3.
28	SECTION 38. [EFFECTIVE JULY 1, 2002] Notwithstanding any
29	other provision of this act, the following are not prohibited or
30	limited:
31	(1) A levy of taxes under IC 12-16-14-1(1) before July 1, 2002,
32	or the collection of those taxes after July 1, 2002.
33	(2) An assessment of taxes under IC 12-16-14-1(2) before July
34	1, 2002, or the collection and allocation of those taxes after
35	July 1, 2002.
36	SECTION 39. [EFFECTIVE JULY 1, 2001] (a) As used in this
37	SECTION, "office" refers to the office of the secretary of family
88	and social services established by IC 12-8-1-1.
39	(b) The office shall apply to the federal Health Care Financing
10	Administration for approval of the necessary state plan
1	amendment and demonstration waiver (42 U.S.C. 1396 et seq.) to
12	implement the uninsured parents program established under



1	IC 12-17.7, as added by this act, as a nonentitlement Medicaid
2	program.
3	(c) The office may not implement a state plan amendment or a
4	waiver until the office files an affidavit with the governor attesting
5	that both the amendment and waiver applied for under this
6	SECTION are in effect. The office shall file the affidavit under this
7	subsection not later than five (5) days after the office is notified
8	that both the amendment and the waiver are approved.
9	(d) If the office receives approval of the state plan amendment
10	and waiver request from the federal Health Care Financing
11	Administration and the governor receives the affidavit under
12	subsection (c), the office shall implement the state plan amendment
13	and waiver on the earlier of the following dates:
14	(1) Thirty (30) days after the governor receives the affidavit
15	under subsection (c).
16	(2) June 30, 2003.
17	(e) Notwithstanding subsection (d), the office shall not in any
18	event implement the state plan amendment and waiver:
19	(1) before July 1, 2002; and
20	(2) before requisite funds for the program's implementation
21	are available or projected to be available, as determined by
22	the office.
23	(f) As soon as possible after the date that the office implements
24	the state plan amendment and waiver, the office shall:
25	(1) publish a public notice; and
26	(2) adopt a rule under IC 4-22-2;
27	stating the implementation date of the uninsured parents program.
28	(g) If the office does not file an affidavit under subsection (c):
29	(1) the office may not implement IC 12-17.7, as added by this
30	act;
31	(2) any funds in a county uninsured parents program fund
32	shall be returned to the county's hospital care for the indigent
33	fund; and
34	(3) any funds in the state uninsured parents program fund
35	shall be returned to the state hospital care for the indigent
36	fund.
37	(h) This SECTION expires July 31, 2003.
38	SECTION 40. An emergency is declared for this act.



COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1727, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, between lines 10 and 11, begin a new paragraph and insert: "SECTION 3. IC 12-7-2-24.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 24.5. "Caretaker relative" for purposes of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2."

Page 4, between lines 16 and 17, begin a new paragraph and insert: "SECTION 4. IC 12-7-2-69 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69. (a) "Division", except as provided in subsections (b) and (c), refers to any of the following:

- (1) The division of disability, aging, and rehabilitative services established by IC 12-9-1-1.
- (2) The division of family and children established by IC 12-13-1-1.
- (3) The division of mental health established by IC 12-21-1-1.
- (b) The term refers to the following:
 - (1) For purposes of the following statutes, the division of disability, aging, and rehabilitative services established by IC 12-9-1-1:
 - (A) IC 12-9.
 - (B) IC 12-10.
 - (C) IC 12-11.
 - (D) IC 12-12.
 - (2) For purposes of the following statutes, the division of family and children established by IC 12-13-1-1:
 - (A) IC 12-13.
 - (B) IC 12-14.
 - (C) IC 12-15.
 - (D) IC 12-16.
 - (E) IC 12-16.1.
 - **(F)** IC 12-17.
 - (F) (G) IC 12-17.2.
 - (G) (H) IC 12-17.4.
 - (H) (I) IC 12-18.
 - (I) (J) IC 12-19.

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- (J) (K) IC 12-20.
- (3) For purposes of the following statutes, the division of mental health established by IC 12-21-1-1:
 - (A) IC 12-21.
 - (B) IC 12-22.
 - (C) IC 12-23.
 - (D) IC 12-25.
- (c) With respect to a particular state institution, the term refers to the division whose director has administrative control of and responsibility for the state institution.
- (d) For purposes of IC 12-24, IC 12-26, and IC 12-27, the term refers to the division whose director has administrative control of and responsibility for the appropriate state institution.

SECTION 5. IC 12-7-2-76, AS AMENDED BY P.L.128-1999, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

- (b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:
 - (1) IC 12-10-6.
 - (2) IC 12-14-2.
 - (3) IC 12-14-18.
 - (4) IC 12-14-19.
 - (5) IC 12-15-2.
 - (6) IC 12-15-3.
 - (7) IC 12-16-3.
 - (8) (7) IC 12-17-1.
 - (9) (8) IC 12-20-5.5.".

Page 4, between lines 36 and 37, begin a new paragraph and insert: "SECTION 7. IC 12-7-2-104.5, AS ADDED BY P.L.128-1999, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 104.5. "Holocaust victim's settlement payment" has the meaning set forth in IC 12-14-18-1.7 for purposes of the following:

- (1) IC 12-10-6.
- (2) IC 12-14-2
- (3) IC 12-14-18.
- (4) IC 12-14-19.
- (5) IC 12-15-2.
- (6) IC 12-15-3.
- (7) IC 12-16-3.
- (8) (7) IC 12-17-1.

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(9) (8) IC 12-20-5.5.

SECTION 8. IC 12-7-2-110, AS AMENDED BY P.L.142-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 110. "Hospital" means the following:

- (1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.
- (2) For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.
- (3) For purposes of IC 12-16, except IC 12-16-1, IC 12-16.1, the term refers to a hospital licensed under IC 16-21.

SECTION 9. IC 12-7-2-118.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 118.1. "Inpatient days", for purposes of IC 12-16.1-8, has the meaning set forth in IC 12-16.1-8-1.

SECTION 10. IC 12-7-2-131.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 131.3. "Minimum data set", for purposes of IC 12-15-41, has the meaning set forth in IC 12-15-41-1."

Page 5, between lines 41 and 42, begin a new paragraph and insert: "SECTION 10. IC 12-7-2-164 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 164. "Resident" has the following meaning:

- (1) For purposes of IC 12-10-15, the meaning set forth in IC 12-10-15-5.
- (2) For purposes of IC 12-16, except IC 12-16-1, IC 12-16.1, an individual who has actually resided in Indiana for at least ninety (90) days.
- (3) For purposes of IC 12-20-8, the meaning set forth in IC 12-20-8-1.
- (4) For purposes of IC 12-24-5, the meaning set forth in IC 12-24-5-1.

SECTION 11. IC 12-10-12-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 27. (a) **Except as provided in subsection (b),** the agency shall, subject to the approval of the division, designate at least one (1) individual who may authorize temporary admittance to a nursing facility under

- (1) subsection (b); and
- (2) sections 28, 30, and 31 of this chapter without the approval required under this chapter.
 - (b) An individual designated under subsection (a) may **not** authorize

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temporary admittance to a nursing home under subsection (a) for a resident nonresident of Indiana. if the resident:

- (1) has received treatment from and is being discharged from a hospital that is located in a state other than Indiana; and
- (2) will be participating in preadmission screening under this chapter.
- (c) Notwithstanding a rule adopted under section 12 of this chapter, a screening team appointed to screen a nonresident under this section must:
 - (1) conduct its assessment under section 16 of this chapter; and
 - (2) report its findings;

within ten (10) days after its appointment.

SECTION 12. IC 12-15-1-16.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 16.5. Each state department or agency and each local governmental unit shall cooperate with the office who shall conduct a study to examine means in which to cover Medicaid eligible care provided by the departments, agencies, or units with state or local funding.".

Page 6, line 2, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 6, line 6, delete "for the period beginning January 1, 2001, through June 30,".

Page 6, line 7, delete "2001, and for".

Page 6, line 7, after "1997," delete "2001" and insert "2000".

Page 6, line 21, delete "For the period beginning January 1, 2001,".

Page 6, delete line 22.

Page 6, line 23, delete "June 30, 2001, the" and insert "The".

Page 6, line 23, delete "calculate" and insert "identify".

Page 6, run in lines 21 and 23.

Page 6, line 25, delete "IC 16-22 or" and insert "IC 16-22-2, IC 16-22-8, and".

Page 6, line 26, delete "calculated" and insert "identified".

Page 6, line 27, delete ", for the period beginning".

Page 6, delete line 28.

Page 6, line 29, delete "year ending after June 30, 2001,".

Page 6, run in lines 27 and 29.

Page 6, line 31, delete "IC 16-22 or" and insert "IC 16-22-2, IC 16-22-8, and".

Page 6, line 34, delete "through" and insert "and ending".

Page 6, line 40, after "Subtract the" insert "amount calculated under".

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Page 6, line 40, after "TWO" delete "amount".

Page 6, line 40, after "from the" insert "amount calculated under".

Page 6, line 41, delete "amount".

Page 6, between lines 41 and 42, begin a new line block indented and insert:

"STEP FIVE: From the amount calculated under STEP FOUR, distribute to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

- (A) the aggregate payments for covered services made under this article to the hospital, excluding payments under IC 12-15-16 and IC 12-15-19; and
- (B) a reasonable estimate of the amount that would have been paid for the services described in subdivision (1) under Medicare payment principles.

The actual distribution of the amount calculated under this STEP shall be made pursuant to the terms and conditions provided for the hospital in the state plan for medical assistance.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.".

Page 6, line 42, delete "FIVE" and insert "SEVEN".

Page 7, line 1, delete "FOUR" and insert "SIX".

Page 7, line 6, reset in roman "each".

Page 7, line 6, delete "the period".

Page 7, delete line 7.

Page 7, line 8, delete "close of a".

Page 7, line 8, delete "ending after June 30, 2001. Payment for".

Page 7, delete line 9.

Page 7, line 10, delete "be made before December 31, 2001." and insert "Payment for a state fiscal year ending after June 30, 2001, shall be made before December 31 following the state fiscal year's end.".

Page 7, line 13, delete "IC 16-22" and insert "IC 16-22-2".

Page 7, line 18, delete "the period beginning January 1, 2001, through June 30,".

Page 7, line 19, delete "2001, and after the close of".

Page 7, line 19, delete "ending after June" and insert ".".

Page 7, line 20, delete "30, 2001.".

Page 7, line 24, after "fund" insert "the state's share of payments under this section and".

Page 7, line 25, after "IC 12-15-20-2(2)" insert ",".

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Page 7, line 25, after "and" insert "payments for the uninsured parents program under".

Page 7, line 29, delete "FIVE" and insert "SEVEN".

Page 7, between lines 38 and 39, begin a new paragraph and insert:

"(g) For the state fiscal year beginning July 1, 2000, and ending June 30, 2001, the amount calculated under STEP THREE of subsection (b) shall be adjusted to account for the portion of the state fiscal year prior to the effective date of the federal regulation establishing the Medicaid upper payment limit for non-state government owned or operated hospitals at one hundred fifty percent (150%) of Medicare reimbursement rates.

(h) For purposes of calculating the amount under STEP THREE of subsection (b), the amount attributable to the period of the state fiscal year described in subsection (g) shall be the maximum payment amount available without exceeding the Medicaid upper payment limit applicable for non-state owned or operated hospitals for that period.".

Replace the effective date in SECTION 8 with "[EFFECTIVE JULY 1, 2001]".

Page 8, line 7, delete "." and insert "and funds available under IC 12-16-14.1-3.".

Page 9, between lines 8 and 9, begin a new paragraph and insert: "SECTION 12. IC 12-15-15-12 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 12. The office may not increase the base amount used to calculate reimbursement rates for inpatient and outpatient hospital services over the base amount used by the office on January 1, 2001."

Page 9, between lines 40 and 41, begin a new paragraph and insert: "SECTION 18. IC 12-15-16-3, AS AMENDED BY P.L.113-2000, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 3. (a) For purposes of disproportionate share eligibility, a provider's low income utilization rate is the sum of the following, based on the most recent year for which an audited cost report is on file with the office:

- (1) A fraction (expressed as a percentage) for which:
 - (A) the numerator is the sum of:
 - (i) the total Medicaid patient revenues paid to the provider; plus
 - (ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program (IC

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12-16-2) (before its repeal); and

- (B) the denominator is the total amount of the provider's patient revenues paid to the provider, including cash subsidies; and
- (2) A fraction (expressed as a percentage) for which:
 - (A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment; and
 - (B) the denominator is the total amount of charges for inpatient services.
- (b) The numerator in subsection (a)(1)(A) does not include contractual allowances and discounts other than for indigent patients not eligible for Medicaid.".

Page 12, line 26, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 12, line 42, delete "for the period before January 1, 2001," and insert "for the state fiscal years ending on or before June 30, 2000".

Page 13, delete lines 4 through 28.

Page 13, line 29, delete "(C)" and insert "(B)".

Page 13, line 31, delete "2001" and insert "2000".

Page 13, line 35, delete "IC 12-15-15-1.1" and insert "IC 12-15-15-1.1(b)".

Page 14, line 7, delete "clauses" and insert "clause".

Page 14, line 7, delete "and (C)".

Page 14, line 9, delete "disproportionate" and insert "Medicaid add-on payments to hospitals licensed under IC 16-21 pursuant to a payment methodolgy developed by the office."

Page 14, delete line 10, begin a new paragraph and insert:

"SECTION 13. IC 12-15-41 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 41. Annual Review of Medicaid Nursing Facility Residents

- Sec. 1. "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, used as:
 - (1) a comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program; and
 - (2) a standardized communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.

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- Sec. 2. A nursing facility certified to provide nursing facility care to Medicaid recipients shall submit to the office annually minimum data set (MDS) information for each of its Medicaid residents.
- Sec. 3. (a) The office or the office's designated contractor shall evaluate the MDS information submitted for each Medicaid resident. The evaluation must consist of an assessment of the following:
 - (1) The individual's medical needs.
 - (2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.
 - (3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.
- (b) The assessment must be conducted in accordance with rules adopted under IC 4-22-2 by the office.
- Sec. 4. If the office determines under section 3 that an individual's needs could be met in a setting other than a nursing facility and in a cost effective manner, the office shall counsel the individual and provide the individual with written notice containing the following:
 - (1) The reasons for the office's determination.
 - (2) A detailed description of services available to the individual that, if used by the individual, make the continued placement of the individual in a nursing facility inappropriate."

Page 14, line 16, delete "2001" and insert "2002".

Page 16, line 22, delete "under" and insert "by".

Page 16, line 23, delete ":" and insert ",".

Page 16, line 24, delete "(1)".

Page 16, line 27, delete "; and" and insert ".".

Page 16, run in lines 23 through 27.

Page 16, delete line 28.

Page 16, between lines 28 and 29, begin a new paragraph and insert: "SECTION 19. IC 12-16.1 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

ARTICLE 16.1. HOSPITAL CARE FOR THE INDIGENT Chapter 1. Applicability

Sec. 1. This article applies only if the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement

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an uninsured parents program before July 1, 2003.

Chapter 2. Administration and General Provisions

- Sec. 1. The division shall administer the hospital care for the indigent program under this article.
- Sec. 2. The division shall adopt necessary forms to be used by the patients, hospitals, physicians, and county offices in carrying out the hospital care for the indigent program.
- Sec. 3. The following persons have the same rights and obligations with respect to the hospital care for the indigent program as the persons have with respect to the Medicaid program under IC 12-15-8 and IC 12-15-29:
 - (1) The division.
 - (2) Applicants and recipients of assistance.
 - (3) Insurers.
 - (4) Persons against whom applicants and recipients of assistance have claims.
 - (5) The office of Medicaid policy and planning.
- Sec. 4. To the extent permitted under federal statutes or regulations, patient days for patients under the hospital care for the indigent program shall be included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395ww(d).
- Sec. 5. The hospital care for the indigent program does not apply to inmates and patients of institutions of the department of correction, the state department of health, the division of mental health, or the division of disability, aging, and rehabilitative services.

Chapter 3. Eligibility for Assistance

- Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to pay for any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:
 - (1) Placing the individual's life in jeopardy.
 - (2) Serious impairment to bodily functions.
 - (3) Serious dysfunction of a bodily organ or part.
- (b) A qualified resident is also eligible for assistance to pay for the part of the cost of care that is a direct consequence of the medical condition that necessitated the emergency care.
 - Sec. 2. (a) An individual who is not an Indiana resident is











eligible for assistance to pay for the part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

- (1) Placing the individual's life in jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.
- (b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:
 - (1) The individual meets the income and resource standards established by the division under section 3 of this chapter.
 - (2) The onset of the medical condition that necessitated medical attention occurred in Indiana.
- Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.
- (b) To the extent possible, rules adopted under this section must meet the following conditions:
 - (1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.
 - (2) Be adjusted at least one (1) time every two (2) years.
- (c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21.
- (d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.
- Sec. 4. A hospital shall provide a patient and, if the patient is not able to understand the statement, the patient's representative with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:
 - (1) The hospital has reason to believe that the patient may be indigent.
 - (2) The patient requests a statement of the standards.

Chapter 4. Application for Assistance

Sec. 1. To receive payment from the division for the costs incurred in providing care to an indigent person, a hospital must file an application with the county office of the county in which the hospital is located.







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- Sec. 2. A hospital must file the application with a county office not more than thirty (30) days after the patient has been admitted to the hospital, unless the patient is medically unable to sign the application and the next of kin or legal representative of the patient is unavailable.
- Sec. 3. The division shall adopt rules under IC 4-22-2 prescribing the following:
 - (1) The form of an application.
 - (2) The establishment of procedures for applications.
 - (3) The time for submitting and processing claims.
- Sec. 4. The division and a county office shall make application forms available to a hospital upon request.
- Sec. 5. A hospital or an attending physician may assist the patient in the preparation of an application for assistance under the hospital care for the indigent program.
- Sec. 6. A person who in good faith provides assistance in the completion of an application under this chapter is immune from civil or criminal liability arising from the assistance.
- Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.
- (b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative of the patient, if available, may sign the application.
- (c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a hospital representative may sign the application instead of the patient.
- Sec. 8. (a) A patient may file an application directly with the county office in the county where the hospital providing care is located if the application is filed not more than thirty (30) days after the patient's admission to the hospital.
- (b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

Chapter 5. Eligibility Determinations; Investigations

- Sec. 1. A county office shall, upon receipt of an application of a patient admitted to a hospital, promptly investigate to determine the patient's eligibility under the hospital care for the indigent program.
- Sec. 2. (a) The hospital providing medical care to a patient shall provide information the hospital has that would assist in the verification of indigency of a patient.
- (b) A hospital that provides information under subsection (a) is immune from civil and criminal liability for divulging the











information.

- Sec. 3. If the division or county office is unable, after prompt and diligent efforts, to verify information contained in the application that is reasonably necessary to determine eligibility, the division or county office may deny assistance under the hospital care for the indigent program.
- Sec. 4. The division or county office shall notify, in writing, the patient and the hospital of the following:
 - (1) A decision concerning eligibility.
 - (2) The reasons for a denial of eligibility.
 - (3) That either party has the right to appeal the decision.

Chapter 6. Denial of Eligibility; Appeals; Judicial Review

- Sec. 1. If the division or county office determines that a patient is not eligible for payment of medical or hospital care, an affected person may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person at the person's last known address.
 - Sec. 2. If the division or county office:
 - (1) fails to complete an investigation and determination of eligibility under the hospital care for the indigent program within forty-five (45) days after the receipt of the application filed under IC 12-16.1-4; or
 - (2) fails or refuses to accept responsibility for payment of medical or hospital care under the hospital care for the indigent program;
- a person affected may appeal to the division not more than ninety (90) days after the receipt of the application filed under IC 12-16.1-4.
- Sec. 3. The division shall fix a time and place for a hearing before a hearing officer appointed by the director of the division.
- Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter at least twenty (20) days before the time fixed for the hearing.
- Sec. 5. (a) Following the hearing, the division shall determine the eligibility of the person for payment of the cost of medical or hospital care under the hospital care for the indigent program.
- (b) If the person is found eligible, the division shall pay the reasonable cost of the care to the persons furnishing the care, subject to the limitations in IC 12-16.1-7.
- Sec. 6. A person aggrieved by a determination under section 5(a) of this chapter may appeal the determination under IC 4-21.5.
 - Sec. 7. (a) The division shall adopt rules under IC 4-22-2 that



provide for an administrative appeal procedure that is responsive to the needs of patients and providers.

- (b) The procedure must provide for the following:
 - (1) The location of hearings.
 - (2) The presentation of evidence.
 - (3) The use of telecommunications.

Chapter 7. Cost of Care and Payment

- Sec. 1. The division shall pay the following, subject to the limitations in section 4 of this chapter:
 - (1) The necessary costs of medical or hospital care for indigent patients.
 - (2) The cost of transportation to the place of treatment arising out of the medical or hospital care for indigent patients.
- Sec. 2. (a) Except as provided in section 5 of this chapter, claims for payment shall be segregated by year using the patient's admission date.
- (b) Each year, the division shall pay claims as provided in section 4 of this chapter without regard to the county of admission or that county's transfer to the state fund.
- Sec. 3. A payment made to a hospital under the hospital care for the indigent program must be on a warrant drawn on the state hospital care for the indigent fund established under IC 12-16-14.
- Sec. 4. (a) Each year, the division shall pay two-thirds (2/3) of each claim upon submission and approval of the claim.
- (b) If the amount of money in the state hospital care for the indigent fund in a year is insufficient to pay two-thirds (2/3) of each approved claim for patients admitted in that year, the state's and a county's liability to providers under the hospital care for the indigent program for claims approved for patients admitted in that year is limited to the sum of the following:
 - (1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16.1-14.
 - (2) Any contribution to the fund in that year.
 - (3) Any amount that was appropriated to the state hospital care for the indigent fund for that year by the general assembly.
 - (4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year.
- (c) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 5. Before the end of each state fiscal year, the division shall,



o p v to the extent there is money in the state hospital care for the indigent fund, pay each provider under the hospital care for the indigent program a pro rata part of the one-third (1/3) balance on each approved claim for patients admitted during the preceding year.

Sec. 6. If:

- (1) a claim for a patient admitted during a particular year is not submitted by the deadline established by the division; and
- (2) the failure to submit the claim is not the fault of the provider;

the claim shall be considered a claim for the year the claim is submitted for purposes of payment under this chapter.

- Sec. 7. The division and a county office are not responsible under the hospital care for the indigent program for the payment of any part of the costs of providing care in a hospital to an individual who is not either of the following:
 - (1) A citizen of the United States.
 - (2) A lawfully admitted alien.
- Sec. 8. The division and a county office are not liable for any part of the cost of care provided to an individual who has been determined to be a patient described in the rules adopted under IC 12-16.1-10.
- Sec. 9. IC 12-16.1-2 through IC 12-16.1-16 do not affect the liability of a county with respect to claims for hospital care for the indigent for patients admitted before January 1, 1987.
- Sec. 10. (a) The budget agency shall estimate for each fiscal year the cost savings to the state hospital care for the indigent fund as the result of the provision of Medicaid to an individual described in IC 12-15-2-12 and IC 12-15-2-13.
- (b) The budget agency shall, each fiscal year, recommend to the general assembly that an amount equal to the cost savings described in subsection (a) be transferred from the state hospital care for the indigent fund to the state general fund.
- Sec. 11. Providers eligible for payment under IC 12-15-15-9 may not receive payment under this chapter.
- Sec. 12. All providers receiving payment under this chapter agree to accept, as payment in full, the amount paid for the hospital care for the indigent program for those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost sharing charges.

Chapter 8. Disproportionate Share Providers











- Sec. 1. As used in this chapter, "inpatient days" includes:
 - (1) days provided by an acute care subunit of the provider; and
 - (2) inpatient days attributable to Medicaid and hospital care for the indigent beneficiaries from other states.
- Sec. 2. A payment adjustment consisting of an additional percentage payment for each service paid under the hospital care for the indigent program made to a disproportionate share hospital licensed under IC 16-21 that meets the requirements under section 3 of this chapter.
- Sec. 3. A provider is a disproportionate share hospital if the provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana.
- Sec. 4. A provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) in which:
 - (1) the numerator is the provider's total number of Medicaid and health care for the indigent inpatient days in a cost reporting period; and
 - (2) the denominator is the total number of the provider's inpatient days in that same period.
- Sec. 5. A disproportionate share hospital must receive a twenty percent (20%) adjustment for each service.

Chapter 9. Rate of Payment

Sec. 1. The rate of payment for the services and materials provided by hospitals and physicians under the hospital care for the indigent program is the same rate as payment for the same type of services and materials under the rules adopted by the secretary under Medicaid.

Chapter 10. Rules

- Sec. 1. The division shall, with the advice of the division's medical staff, the division of mental health, the division of disability, aging, and rehabilitative services, and other individuals selected by the director of the division, adopt rules under IC 4-22-2 to do the following:
 - (1) Provide for review and approval of services paid under the hospital care for the indigent program.
 - (2) Establish limitations consistent with medical necessity on the duration of services to be provided.
 - (3) Specify the amount of and method for reimbursement for services.
 - (4) Specify the conditions under which payments will be



C o p denied and improper payments will be recovered.

- Sec. 2. To the extent possible, rules adopted under section 1 of this chapter must be consistent with IC 12-15-21-2 and IC 12-15-21-3.
- Sec. 3. The rules adopted under section 1 of this chapter must include rules that will deny payment for services provided to a patient after the patient is medically stable and can safely be discharged.
- Sec. 4. (a) The division shall adopt rules under IC 4-22-2 necessary to establish a statewide collection system of data concerning the hospital care for the indigent program.
 - (b) The following data must be collected:
 - (1) Patient demographics.
 - (2) Types of services provided by hospitals.
 - (3) Costs of particular types of services provided by hospitals.
- (c) A hospital that provides services under the hospital care for the indigent program shall file copies of all claims submitted under the program with the contractor engaged by the division to adjudicate claims.
- Sec. 5. The division may adopt rules under IC 4-22-2 that are in addition to and consistent with the rules required to be adopted under IC 12-16.1-6 governing appeals brought under the hospital care for the indigent program to the division.

Chapter 11. Recovery of Payments by Division

- Sec. 1. The division may recover amounts paid under the hospital care for the indigent program by the division from the following:
 - (1) A patient approved for assistance.
 - (2) A person legally responsible for those patients approved for assistance.
 - (3) The estate of the patient or person.
- Sec. 2. The division is subrogated, to the extent of the assistance given by the division, to the rights that a patient receiving assistance under the hospital care for the indigent program has against any other person who is in any part liable for the illness or injury for which assistance was granted.
- Chapter 12. County With Health and Hospital Corporation; Responsibility for Medical Cost
- Sec. 1. This chapter applies to a county having a health and hospital corporation created under IC 16-22-8-6.
- Sec. 2. The division is responsible for the emergency medical care given in a hospital to an individual who qualifies for assistance







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under this chapter, subject to the limitations in IC 12-16.1-7.

- Sec. 3. The hospital providing care shall transfer the patient to a hospital operated by the health and hospital corporation as soon as the attending physician determines that the patient's medical condition permits the transfer without risk of injury to the patient.
- Sec. 4. (a) If a hospital owned by the health and hospital corporation is:
 - (1) unable to care for a patient; or
 - (2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital initiating treatment may continue to treat the patient until the patient's discharge.

- (b) Subject to the limitations in IC 12-16.1-7, the division shall pay the costs of care.
 - Sec. 5. The division is not responsible for the following:
 - (1) The payment of nonemergency medical costs, except as provided under the hospital care for the indigent program.
 - (2) The payment of medical costs accrued at a hospital owned or operated by a health and hospital corporation, except for hospital care provided under this chapter to a person not residing in Marion County.

Chapter 13. Immunity

- Sec. 1. A hospital, a physician, or an agent or employee of a hospital or physician that provides services in good faith under the hospital care for the indigent program is immune from liability to the extent the liability is attributable to at least one (1) of the following:
 - (1) The requirement that a patient be transferred under IC 12-16.1-12.
 - (2) The denial of payment under IC 12-16.1-10.
- Sec. 2. Section 1(1) of this chapter does not limit liability for the determination that the patient's medical condition permits a transfer under IC 12-16.1-12.

Chapter 14. Property Tax Levy and Funds

- Sec. 1. A county hospital care for the indigent fund is established in each county. The fund consists of the following:
 - (1) A tax levy on the property located in each county.
 - (2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund.
- Sec. 2. (a) The tax required by section 1(1) of this chapter shall be imposed annually by the county fiscal body on all of the taxable







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property of the county.

- (b) The tax shall be collected as other state and county ad valorem property taxes are collected.
- Sec. 3. Each county shall impose a hospital care for the indigent tax levy equal to the product of:
 - (1) the most recent hospital care for the indigent property tax levied by the county; multiplied by
 - (2) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.
- Sec. 4. The state board of tax commissioners shall review each county's property tax levy under this chapter and shall enforce the requirements of this chapter with respect to that levy.
- Sec. 5. All receipts derived from the tax levy shall be paid into the county general fund and constitute the county hospital care for the indigent fund.
- Sec. 6. (a) The state hospital care for the indigent fund is established.
- (b) Before the fifth day of each month, all money contained in a county hospital care for the indigent fund at the end of the preceding month shall be transferred to the state hospital care for the indigent fund.
- Sec. 7. (a) The state hospital care for the indigent fund consists of the following:
 - (1) Money transferred to the state hospital care for the indigent fund from the county hospital care for the indigent funds.
 - (2) Any contributions to the fund from individuals, corporations, foundations, or others for the purpose of providing hospital care for the indigent.
 - (3) Money advanced to the fund under IC 12-16.1-15.
 - (4) Appropriations made specifically to the fund by the general assembly.
- (b) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.
- Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund to defray the expenses and obligations incurred by the division for hospital care for the indigent. The money in the fund is hereby appropriated.
 - Sec. 9. Money in the state hospital care for the indigent fund at











the end of a state fiscal year remains in the fund and does not revert to the state general fund.

Chapter 15. Advancements From State Fund

- Sec. 1. The division may request an advancement of money from the state general fund in anticipation of county property tax revenue being transferred to the state hospital care for the indigent fund.
- Sec. 2. (a) The budget director shall determine an interest rate that is at least the interest rate earned by the state on investments made from money in the state general fund.
- (b) The interest rate shall be paid on the amount that is advanced from the state general fund.
- Sec. 3. The amount that may be advanced, plus the projected interest on that amount, may not exceed the amount of county property tax revenue that is expected to be transferred to the state hospital care for the indigent fund during the six (6) months following the date of the request.
- Sec. 4. A request for an advancement must be submitted to the budget agency.
- Sec. 5. The state board of finance may, on the recommendation of the director of the budget agency, approve an advancement.
- Sec. 6. If an advancement is approved, the county property tax revenue transferred to the state hospital care for the indigent fund shall be immediately used to repay the amount of the interest and advancements made under this section.

Chapter 16. Review of Medical Criteria

- Sec. 1. The division shall review changes made after 1985 in the medical criteria used to establish whether a patient is eligible for assistance under IC 12-16.1-3.
- Sec. 2. The division's review under this chapter must include the application of the criteria to specific cases and address whether changes to or clarification of the criteria is necessary so that, in practice, the criteria are consistent with the hospital care for the indigent program.
- Sec. 3. The division shall provide to an interested party a report of the division's review, including the division's findings, conclusions, and recommendations."
 - Page 16, between lines 35 and 36, begin a new paragraph and insert:
- "Sec. 2. (a) "Caretaker relative" means a blood relative and those of half blood.
- (b) The term includes an adoptive parent, grandparent, sibling, and a relative of an adoptive parent.









(c) The term also includes a spouse of an individual described in subsection (b), even after the marriage is terminated by death or dissolution."

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Page 16, line 36, delete "2." and insert "3.".
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Page 17, line 5, delete "3." and insert "4.".

Page 17, line 7, delete "4." and insert "5.".

Page 18, line 21, delete "parent" and insert "caretaker relative".

Page 19, between lines 30 and 31, begin a new paragraph and insert:

"Sec. 4. (a) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to or greater than the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2:

- (1) Prescription drugs.
- (2) Mental health services.
- (3) Vision services.
- (4) Hearing services.
- (5) Dental services.
- (b) The office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses."

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Page 19, line 31, delete "4." and insert "5.".
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Page 19, line 33, delete "5." and insert "6.".

Page 20, line 18, delete "has" and insert "shall have".

Page 22, line 5, delete "not" and insert "only".

Page 22, line 5, delete "any person" and insert "the following:

- (1) Another provider involved or potentially involved in the care of the individual.
- (2) A person who:
 - (A) works under the authority of a provider described in subdivision (1); and
 - (B) requires the information for the provider's legitimate business or clinical purposes.".

Page 22, between lines 15 and 16, begin a new paragraph and insert:

"Sec. 1. This chapter applies beginning July 1, 2002.".

Page 22, line 16, delete "1" and insert "2".

Page 22, line 29, delete "2" and insert "3".

Page 22, line 29, delete "1(a)(1)" and insert "2(a)(1)".

Page 22, line 34, delete "1(a)(1)" and insert "2(a)(1)".

Page 22, line 37, delete "3" and insert "4".

Page 22, line 37, delete "sections 4 and 5" and insert "sections 5



and 6".

Page 22, line 37, delete "section 5" and insert "section 6".

Page 22, line 42, after "equal" insert "ninety percent (90%) of".

Page 23, line 9, after "equal" insert "ninety percent (90%) of".

Page 23, line 27, delete "4" and insert "5".

Page 24, line 14, delete "3(3)" and insert "4(3)".

Page 24, line 15, delete "5" and insert "6".

Page 25, line 2, delete "3(3)" and insert "4(3)".

Page 25, line 3, delete "6" and insert "7".

Page 25, line 6, delete "7" and insert "8".

Page 26, between lines 39 and 40, begin a new paragraph and insert: "SECTION 26. IC 34-30-2-45.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 45.5. IC 12-16.1-4-6 (Concerning persons who aid a patient in completing an application for assistance under the hospital care for the indigent program).

SECTION 27. IC 34-30-2-45.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.7. IC 12-16.1-5-2 (Concerning hospitals for providing information verifying indigency of patient).**

SECTION 28. IC 34-30-2-45.9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 45.9. IC 12-16.1-13-1 (Concerning hospitals or persons providing services under the hospital care for the indigent program)."

Page 27, delete lines 19 through 23.

Page 27, line 24, after "19." insert "IC 12-10-12-27.1; IC 12-10-12-28.5".

Page 27, between lines 27 and 28, begin a new paragraph and insert: "SECTION 30. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2002]: IC 12-7-2-118; IC 12-16-2; IC 12-16-3; IC 12-16-4; IC 12-16-5; IC 12-16-6; IC 12-16-7; IC 12-16-8; IC 12-16-9; IC 12-16-10; IC 12-16-11; IC 12-16-12; IC 12-16-13; IC 12-16-15; IC 12-16-16; IC 34-30-2-44; IC 34-30-2-45; IC 34-30-2-45.3."

Page 27, line 28, delete "JUNE 30" and insert "JULY 1".

Page 27, delete lines 36 through 42.

Page 28, delete lines 1 through 3.

Page 28, between lines 26 and 27, begin a new paragraph and insert:

"(e) Notwithstanding subsection (d), the office shall not in any event implement the state plan amendment and waiver:

(1) before July 1, 2002; and

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(2) before requisite funds for the program's implementation are available or projected to be available, as determined by the office.".

Page 28, line 27, delete "(e)" and insert "(f)".

Page 28, line 32, delete "(f)" and insert "(g)".

Page 28, line 41, delete "(g)" and insert "(h)".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

Committee Vote: yeas 22, nays 1.

(Reference is to HB 1727 as introduced.)

BAUER, Chair

